			For State Registrar	State of Mai	ryland / Depa <i>Ce</i>	artment of H rtificate of L		Reg	ene LNo.2 () (	17	21501
H	Physici		1. Decedent's Name (First, Middle, Las Sarah Elizab		er Row			2. Date of Death June	<sup>12</sup> 1 2		3. Time of Death 10:09A M
	/Medic Examin		4a. Fecility Name (If not institution, give		tage 83		Location of Death		4c. County of Washi		County
	Funeral Director		E Social Security Number 6 S		(In yrs. last birthday) 86 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, ) NOV 10	<sup>∕•ar)</sup> 1920	9. Birthplac Country M1SS	e (State or Foreign
	Maryland -f ehow	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland Wash	ington	10c. City, Town or Lo	ocation Villiamspo	rt			10d.	Inside City Limits 1 ☐ Yes 2 No
	with the	Direc	10e. Street and Number 16505 Virginia	Avenue Co	ottage 83	10f. Zip Code	1795	109	g. Citizen of Wh	nat Country	?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: if Item 27 is marked other then "neturel; or Items 23a or 28a-f show eny injury or other traumatic event, the Medical Examinar must be notified at ODGE.	by Funeral Director	11. Marital Status  1 Never Married 2 Marned  3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1Yes2\(\bar{\Delta}\) No If Yes, Give Year or Dates:	ver in U.S. 13.	Was Decedent of H If Yes, specify Cuba		pecify Yes or No- p Rican, etc.)	14. Race Black,	- American White, etc White	
21215-0036	within 72 ho ene. then "netur the Medical I	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	lucation de completed) College (1-4or 5+	(Give	dent's Usual Occupion kind of work done of DO NOT use retired	during most of worl )	king	Sd. of H		
and 2	d be filed ontal Hygie ed other is event, it	Be	17. Father's Name (First, Middle, Last)  Melvin Randolp			BCHOOT TO	18. Mother's Nam	ne (First, Middle, Ma Teel Carpe	aiden Sumame		
Maryland	d 2 shouk th and Me 7 is mark traumati	٦٥.	19a. Informant's Name/Relationship (1) Linwood Parker	Type, Print)	19b. Maili		and Number or Ru	ral Route Number, (	City or Town, S		
Baltimore, I	Pages 1 and ent of Healt of Healt of Healt of them 2 ry or other		20a. Method of Disposition  1 Durial 2 Cremation 3 4 Donation 5 Other (Specify	Removal from State	20b. Place of Dispo cemetery, cre		a)		oc. Location - C	ity or Town	, State
Balti	permit. Departm importe eny inju		21. Signature of Funeral Service Licen					ouglas A. N. Hager			
	Physician be executed buyerician and physician and physician superior is the burial-transit	i Examiner	23a. Part . Enter the disease, or compshock, or hear failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a		THE MODE OF DYIN			st,	In O	pproximate terval Batween nset and Death
Division of Vital Records, P.O. Box 68760,	Attending Physician: The law requires that the death certificate be executed to death.  - death.  - ector: After this certificate has been signed by the attending physicien and ector: the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d	Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date Mont	of delivery	ay Year
rds, P	quires that in signed t uld be det	Ď	Part II. Other significant conditions of MYEU BYSPU	-	not resulting in the u	_	en in Part I.				cause of death?
I Reco	The law requir ate has been si page 2 should I	Completed						24a. Was an autopsy perform	24b. W pr de X No 1[	ere autopsy for to comp eath?	y findings available letion of cause of ☐ No
Vita V	iclan: sertific ector,	Be	25. Was case referred to medical examiner?	Uosaital:		0#		th (Check only one	)		
o	Physic this cal dir	. To	1 ☐ Yes 2 ☑ No 27. Manner of Death		t 2 ☐ ER/Outpatier		4 LI Nursing H	ome 5 Residen			
ision	To the Hospital or Attending Physician: The law within 24 buous after death.  To the Funeral Director Attenthis certificate has completely filled in by the funeral director, page 2	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be		Year) Injury	M 1	Yes 2 □ No	28f. Location (Stre			loute Number,
É	To the Hospital or Attenwithin 24 hours after deation to the Funeral Director: completely filled in by the		4 Homicide determined	building, etc. ysician: To the best of	(Specify)		ne, date and place	City or Town,	State)		
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical	(Check only 2 Medical Examone)	niner: On the basis of e and manner state	examination and/or in	vestigation, in my o	oinion, death occu	rred at the time, dat	e and place, ar	nd due to th	e cause(s)
r	To the To the Comp	ž	29b. Signature and title of certifier	7		29c. Licens	number	29	d. Date signed	(Month, Da	y, Year)
			JEHOUR	e, mo		03.	3700	J	WE Z	7,	2007
34	-10		30. Name and address of person who TEDE. HOWE	154 N	ath (Item 23a) (Type, AZTIZAA		WILLIA	MSPORT	, MD	21	795
	Sta		31. Date filed (Month, Day, Year)	32. Registrar	's Signature	a de					

			1 - For State Registrar	State of N	Maryland		artment rtificate			ınd Me		ene	007	2	502
	Physici	.≈ an ,	Decedent's Name (First, Middle, Last, Gwendolyn	)	S	mith				2.	Date of Death Month June		2007	3. Time o	
	/Medic Examin		4a. Facility Name (If not institution, give Prince Georges Hos					own, or	Location o	f Death	ounc	4c. Co	ounty of Deat		
	Funeral Director		370-13-7029	X 7. A	Age (In yrs. las 79	t birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours		Date of Birth Month, Day 18/19	year) 27	9. Bird St.	hplace (State bunity) Vince	or Foreign nt
	Maryland	tor	Usual Residence of Decedent  10a. State 10b. County  MD Prince Ge	eorges	10c. City, 1		cation							10d. Inside (	City Limits
	3a or 28	I Director	10e. Street and Number 9224 Alcona St.				10f. Zip (	Code 706			10		n of What Co	ountry?	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural", or Items 23a or 28a-f show any Injury or other traumatic event, I're Medical Examinat must be notilised at ODEs.	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	12. Was Deceder Armed Forces 1  Yes 2 If Yes, Give Year or Dates	s? No		Was Decede f Yes, speci	rty Cubai	n, Mexican	gin? (Specif , Puerto Ric	y Yes or No- can, etc.)		Race - Ame Black, Whit becify: B1	e, etc.	
Baltimore, Maryland 21215-0036	d within 72 ho giene. er then "netur . It's Medical	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0·12) 12th		r 5+)	(Give	dent's Usual kind of work DO NOT use	k done d	lunna most	of working	1		of Business vate	Industry	
yland	Mental Hygarked other	To Be C	17. Father's Name (First, Middle, Last) David Charles	Tesheira	a						First, Middle, M Cato	aiden Su	mame)		
, Mar	and 2 sho saith and a 27 ie m er traum		19a. Informant's Name/Relationship (T) Asley Tesheira /				Alcon				oute Number, MD 2	0706		Zip Code)	
more	Pages 1: nent of He int: if Iten iry or oth		20a. Method of Disposition  1   Burial 2 □ Cremation 3 □ F  4 □ Donation 5 □ Other (Specify)		cem	etery, crer	sition (Nam natory or oti eaven	her place	9)	Date 06/23	100		er Sp	Town, State	Œ
Balti	permit. Dapartn Importe eny Injk		21. Signature of Funeral Service Licens	Lan	du-						son & J Washing			neral I 20011	lome
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or come shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	Due to (or a	ac Arr	est	er the mode	of dying	, such as	cardiac or n	espiratory arre	st,		Approxima Interval Be Onset and	tween
8760,	icate be executed physician and stha burial-transit	al Examiner	Sequentially list conditions, 1 any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Acute Stenosis  Due to (or as a consequence of):  Atrial Fibrillation  Due to (or as a consequence of):  Diabetes Mellitus												
O. Box 6	ath certif ttending or use es	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal de at time of deat	ath 3	Ectopic pre					230	d. Date of del Month	ivery Day	Year
rds, P.	w requires that the de been signed by tha a should be detached f	5	Part II. Other significant conditions co	ntnbuting to death	but not resulti	ng in the u	nderfying ca	use give	in in Part I.			acco use		the cause of obably 4	
l Reco		Completed									24a. Was an autopsy perform 1 Yes 2	ed? DNo	death?	itopsy findings completion of	s available cause of
/ita	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	1				100		of Death (C	Check only one	)			
o	Physical this call direct	10	1 ☐ Yes 2X No  27. Manner of Death	Hospital:		VOutpatier Bb. Time of			4 🗀 1401		5 Resider			cify)	
Division of Vital Records,	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific compisiely filled in by the funeral director.	Certification:	1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined	28a. Date of In (Month, D 28e. Place of I building,		Injury	М		di ?? ∕es 2 □ h	40	Location (Str. City or Town,	eet and N		ural Route Nu	mber,
	To the Hospital of within 24 hours at 1 To the Funeral D completely filled in	Medical Cer	29a Certifier 1	sigian: To the beiner: On the basis and manner:	of examination	oga, ceat n and/or in	oncurred a vestigation,	it the tim	a date an inion, deat	d place, and h occurred	d due to the rea at the time, da	use(s) an te and pl	d risinner at ace, and due	stated.	(s)
)	To the Vithin To the Complete	Me	29b. Signature and title of certifier  Stum	Tu			29c.		number	998	29	d. Date s	)	h, Day, Year)	
	731		30. Name and address of person who con Steven Tee MD. 34	ompleted cause of 15 Hamil	death (Item 2)	3a) (Type, #1	Print) Hyatts				782	<u> </u>		000	
100	Sta	ite	31. Date filed (Month, Day, Year)	32. Regis	strar's Spriatur	25		_							

			For State Registrar	State o	f Maryland / D		artmeni rtificate			and M	,	giene Reg. No.	may	21503
	Physici	an	1. Decedent's Name (First, Middle	e, Last)							2. Date of Dea	ath Day	Year	3. Time of Death
	- /Medic		Busai		eckar						06	15	2007	12:20p <sup>M</sup>
}	Examir	er	4a. Facility Name (If not institution		mber)				Location o	of Death			unty of Death	
			Casey House 5. Social Security Number	6. Sex	7. Age (In yrs. last birt.	thday)	If Under		ille If Under:	24 Hrs	8. Date of Birt		ntgome	ace (State or Foreign
	Funeral Director		057-90-1946	1 □ M 2 🖾 F	4 4	Yrs.	Months	Days	Hours	Min.	(Month, Day	v, Year)	Count	ry)
	ъ		Usual Residence of Decedent							1	0/23/	1905	Ster	ra Leone
	arylar show d at	_	Md. Frede	ri ak	10c. City, Town								10	d. Inside City Limits
	he Ma-f	Director		TICK	rrede.	110								1 X Yes 2 □ No
	a or a	ä	10e. Street and Number 1011 Chinabe	rry Driv			10f. Zip	703					of What Count	
	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examiner must be notified at	Funeral	11. Marital Status	<del></del>	edent Ever in U.S.	13. \			isnanic Orie	gin? (Sne	cify Yes or No-		Race - America	
က	or iter		1 ☐ Never Married 2 ☐ Marri	Armed Fo	orces? 2 <b>X</b> ] No		_	_		i, Puèrto I	cify Yes or No- Rican, etc.)		Black, White, e	
ğ	ral", c	l by	3 ☐ Widowed 4 ☑ Divorced	If Yes, Gi Year or D	ve ates:		1 ☐ Yes 2	No LI	Specity:			ıck		
2-(	"natu	lete	15. Decedent (Specify only highes	t's Education st grade completed)	16a.	Deced (Give	dent's Usua kind of wor DO NOT us	l Occupa k done d	ation <i>Juring mos</i> i	t of workir	ng	16b. Kind	of Business/Ind	ustry
21215-0036	withir ene. than the Mo	Completed	Elementary/Secondary (0-12)	College (	1~40r5+1 I	al			, ager			Ret	ail	
<b>Q</b>	filed Hygi Other ent, t		17. Father's Name (First, Middle,	Last)						r's Name	(First, Middle,	Maiden Su	rname)	
/lan	uld be Aenta rked tic ev	To Be	Mohammed Al	ie Sec	kar				Ali	ima	Kaike	eemba		
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relations Maimunatu Ro	hip (Type. Print)									own, State, Zip	
<u>გ</u>	is 1 and 2 of Health a item 27 is other trai													21703
Baltimore,	ages int of h		20a. Method of Disposition 1   Burial 2 □ Cremation		State 20b. Place of cemeters	v, cren	natory or of	her place	e)		ate		ion - City or Tov	
ij	artme ortant Injury		4 □ Donation 5 □ Other (S		Maryi		. Name and						cel, Mo	
Ba	Depril Impo		1 max	lasta						01.			ortuary	OC 20011
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that conty one cause on e	aused the death. Do n									Approximate Interval Between
	Physician	9	Immediate Cause (Final disease or condition		Multiple	М	yelo	ma						Onset and Death
7	/Medical Examiner		resulting in death)		(or as a consequence o		7010							
	- Adminior	<u>~</u>	Sequentially list conditions,	b. Due to	or as a consequence o	ıf)·								
	uted I Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	540 10	or as a sonsequence o									
oʻ	exec an and rial-tra	Exa	that initiated events resulting in death) Last	C. Due to	or as a consequence o	of):								
8760,	ate be executed hysician and the burial-transit	dical		d										
ဖ	ertifica ling ph e as t	Med	IF FEMALE:											
Вох	leath certific attending p	ian/	23b. Was decedent pregnant in the past 12 months?	1 ☐Live b	come pf pregnancy birth 2  Fetal death		Ectopic pre					23d	. Date of deliver Month	y Day Year
P.O.	the de	Physician/Mec	1 ☐ Yes 2 █ <b>X</b> No 9 ☐ Unknown	4⊟Pregr 9⊟Unkn	eant at time of death	5	Other (spe	ecity)						
σ <u>.</u>	The law requires that the death certific the has been signed by the attending pinage 2 should be detached for use as to		Part II. Other significant condition	ens contributing to de	eath but not resulting in	the ur	nderlying ca	use give	en in Part I.		23e. Did to	bacco use	contribute to the	e cause of death?
rds	quires	ed by									1 🗆 Y	es 2□N	lo 3 ☐ Proba	ıbly 4.⊠Unknown
000	law re as bee 2 sho	Completed									24a. Was a		4b. Were autop	sy findings available
Division or Vital Records,		mo;									autop perfor 1∐ Yes	med?	death?	pletion of cause of 2∰No
/ita	cian: ertific ector,	Be	25. Was case referred to medical examiner?							of Death	(Check only or			
or.	Physic this o	2	1 Yes 2 No		npatient 2 ER/Out				4 L 14ul	-			Other (Specify,	Hospice
u	ding I	ion	27. Manner of Death  1 XNatural 5 ☐ Pending			ime of ijury	M 28	Bc. Injury Work	rat :? /es 2∐:N		8d. Describe h	ow injury o	ccurred	
<u>ISi</u>	or Attending Physician: after death. Director: After this certifics in by the funeral director, p	ficat	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could n	ot be	of injury - At home, fare	m, stre	1		169 2 1		8f. Location (S	treet and N	umber or Rural	Route Number,
	i diffe	Certification:	4 ☐ Homicide determi	buildi	ng, etc. (Specify)		, , .				City or Tow		and or manar	riodio ridiniboli,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier 1 X CertifyIn	g Physician: To the	best of my knowledge, asis of examination and	death	occurred a	t the tim	ne, date an	d place, a	and due to the	ause(s) and	d manner as sta	ated.
	the H hin 24 the F nplete	Medical	one)	and mani	ner stated.	J/O1 111V				ur occurre				
	So 7 kit	<	29b. Signature and title of certifier	1.1. /	2 6 1	. `	- 1		number	11			gned (Mo <i>nth, E</i>	ay, Year)
	/,		mayere	Wrohl	BUST M			00	64	9/	3	0/13		
	67		30. Name and address of person of Genevieve Wro				-	r M	i]] 1	Rd₋	Rocky	ille.	Md. 3	20855
	Sta	te	31. 101 (19 / 2007 Year)		distrar's Committee	,							-100	
	Registra	ar	1011 20		20									

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) June 18 2007 ar 10:30ам Grace Schnebly Physician Genevieve /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Clear Spring Washington 14706 Fairview Road Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Dec. 8, 1930 Birthplace (State or Foreign Country)
 MD 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 76 1 □ M 2 🖸 F 217-28-2223 Yrs. **Director** Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10b. County 10a. State h and Mental Hygiene. 7 is marked other then "neturel", or Items 23s or 28e-f show treumatic event, the Medical Examinat must be notified at 1 ☐ Yes 🏖 No Clear Spring, MD Washington Director 10g. Citizen of What Country? 10f. Zip Code 21722 10e. Street and Number 14706 Fairview Rd. Funerai Pages 1 and 2 should be filed within 72 hours after death 14 Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. White ☐ Yes 2 XNo Yes, Give 1 Never Married 20 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: þ 3 Widowed 4 Divorced Year or Dates: Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) residence College (1-4or 5+) Elementary/Secondary (0-12) Homemaker 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Pearl Harsh Walter Perry Beckley Sr ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
14706 Fairview Rd. Clear Spring, MD 21722 19a. Informant's Name/Relationship (Type, Print) Seth K. Schnebly husband permit. Pages 1 and 2 Department of Health a Importent: If item 27 Is any injury or other treu once. Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition June 21 1 Surial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Clear Spring, MD St. Paul Cemetery 2007 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Donald Edwin Thompson Funeral Home, Inc P.O.BOX 310 Clear Spring, MD 21722 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart/failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician SUDDEN MJOCARDIAL INFA RETION ACUTE /Medical Due to (or as a consequence of): **Examiner** HEART ARTEKIOSC 6 THATTIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, by 2 1 No 3 Probably 4 Unknown 1 🗌 Yes Completed been s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has 1 ☐ Yes 2 ☐ No this certificate 1 Yes 2 No in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Cther: 4 ☐ Nursing Home 5 esidence 6 ☐ Other (Specify) 1 Yes 2 Certification; To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manne After Injury 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 | Homicide Hospitel 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical within 2 To the To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 10001040 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HAGENDON, MD OH-10 22 E. MNTIETAM COMEN 32. Degistrar's Signature 31. Date liled (Month, Day, Year) State JUN 2 0 2007 Registrar

07-04839 Sandra Smith

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Janara Omman		or State	or waryland /	Certific			a monta		g. No.		
Physician Medical Examine	1. [	Decedent's Name (First, Middle,La Sandra Lee			-			2. Date of Death Month June 23, 20	Day Year	3. Time of Death 2146 hrs	
<i>2</i>	4a.	Facility Name (if not institution, gi University Hospital	ve street and number)			City, Town, or Baltimore	Location of I		4c. County of D		
Funeral Director	- 1	6. Social Security Number 6. Social Security Number 16–80–3441	Sex 7. Age M 2XF	(In yrs. last birl	hday) Yrs.	If Under 1 Yea Months Days		Min.		Birthplace (State or oreign Country)	
land f show any once.	10a	a. State 10b. County  MD Calv		Oc. City, Town	Fred	erick		Lie	O'line of Mines	10d. Inside City Limits 1 Yes 2 X No	
the Maryland as or 28a-f sh		e. Street and Number 208 Augustus Dri	ive			0f. Zip Code <b>20</b> 6	578	10	g. Citizen of What USA	Country?	
imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.  The marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once.	1 3	Marital Status  Never Married 2 X Marrie  Widowed 4 Divorce	12. Was Decedent E Armed Forces? 1 Yes 2	ver in U.S.	If Yes		n, Mexican, P	n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: White		
5-0036 ed within 72 hours aft yigene other than "natural" the Medical Examine		5. Decedent's Education (Specify of Elementary/Secondary (0-12)	college (1-4 or 5-	+)	during mos	Usual Occupa t of working life istrati	. DO NOT us	nd of work done se retired)	16b. Kind of Busin	3 1 1 3	
Baltimore, MD 21215-0036 permit. Pages I and 2 stould be filed within 7 Department of Health and Mental Hygiene. Important: If tiem 77 is marked offer than injury or other traumatic event, the Medical To Be Comple	n l	Father's Name (First, Middle, Las George a. Informant's Name/Relationship	C	omparet			Ju	Name (First, Middle, M $\mathrm{d} y$ er or Rural Route Num	,	Holmes	
MD 2 nd 2 shoul alth and M m 27 is m aumatic	L	Terri Mead (dau	ighter)	9	032 C		Point 1	Road Glen		'A 23060	
Baltimore, permit. Pages I ar Department of Heg Important: If ite Important: If ite Imjury or other ir	1 4	a. Method of Disposition  Burial 2 X Cremation 3  Donation 5 Other Specif	fy:	te crema	tory or othe Crema	tory		Jun 26 2007	Clinton	, MD	
Balt permit. Depart Import injury		Signature of Funeral Service Lice	Ŧ		812	5 South	nern M	aryland Bl	vd. Owin		
Physician /Medical aminer	lm	a Faut. Enter the disease, or con failure. List only one cause on a mediate Cause (Final disease condition resulting in death)		ns of ac					st, shock, or heart	Approximate Interval Between Onset and Death	
ed nsit		equentially list conditions, any, leading to immediate use. Enter Underlying Cause isease or injury that initiated	Due to (or as a conse								
ecuted and transit			d								
	IF 23b	X UNPENDED AMS DEC 27, 28a-f, perME, g869, 7/5/07 TT    IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1  Yes 2  No 9  Unknown									
P.O. Bores that the dearsigned by the a	ρ P P P P P P P P P P P P P P P P P P P	art II. Other significant condition:	3 Officiowii	but not resultin	ng in the un	derlying cause	given in Part			te to the cause of death?  Probably 4  Unknown	
Records The law requi	Completed							1 🗸 Yes	sy price dea	re autopsy findings available or to completion of cause of ath?  Yes 2 No	
of Vital ling Physician: After this certifuneral director	99 25 0 27	i. Was case referred to medical examiner?  1  Yes 2 No  7. Manner of Death  Natural 5 Pending	28a. Date of Inju (Month, Day,Yo	/aaam   .	Time of Inj	3 DOA	Othor	28d. Describe	Residence 6 now injury occurred	Other:	
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	Accident Investig: Suicide 6 X Could no determin	ation 28e. Place of Injury (Specify) Re	ury-Athome, sidence	farm, street	factory, office	building, etc	. 28f. Location (Sor Town, Sor 11915 Mil	tate) 1 Bridge Ro	or Rural Route Number, City	
To the How within 24 h To the Fur completely	_   29	la. Certifier 1 Certifying Phys theck only 2 Medical Examir	ician: To the best of my ner:On the basis of exar and manner stated.	/ knowledge, de mination and/or	eath occurre investigation	ed at the time, on, in my opinio	date and place on, death occ	ce, and due to the caus urred at the time, date	e(s) and manner as and place, and due	s stated.  to the cause(s)	
	29	bb. Signature and title of certifier	Hell	Qai			.M.E.		June 26, 200	(Month, Day, Year)	
	30	. Name and address of person wh Carol Allan, MD Assis	o completed cause of d tant Medical Exan			treet, Baltin	nore, MD	21201			
Sta Registra	te <sup>31</sup> ar	. Date filed (Month, Pay Year)	2007 32. Redistra	r's Signature	Con	ules					
DHMH 17 Rev 1/200	01		00115	0	RIGINAL						

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 8:30 P M Charlotte Louise Sloan 2007 June 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 6560 Cardinal Drive La Plata Charles Under 1 Year | If Under 24 Hrs. onths | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 M 2 XF 134-09-8007 87 April 3,1920 New York Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County Charles 1 ☐ Yes 2 X No La Plata 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6560 Cardinal Drive 20646 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14 Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 💢 No Specify. Specify: White 3 X Widowed 4 ☐ Divorced

(Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

20c. Location - City or Town, State

Cheltenham, Maryland

Approximate Interval Betwee Onset and Dea

18. Mother's Name (First, Middle, Maiden Surname)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Date

July 11,2007

4220 Majestic Lane Fairfax, Virginia 22033

AREHART-ECHOLS FUNERAL HOME, P.A.

211 St. Mary's Ave. La Plata, MD

Ethel Geneviene Hotaling

Telephone Company

16a. Decedent's Usual Occupation

Secretary

20b. Place of Disposition (Name of

Maryland Veterans

complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, may one cause on each line.

Cemetery

**Physician** /Medical Examiner

The law requires that the death certificate be execute

Division or Vital Records, P.O. Box 68760,

**Physician** 

/Medical

10a. State

MD

Elementary/Secondary (0-12)

17. Father's Name (First, Middle, Last)

Clarence John Goodgion

19a. Informant's Name/Relationship (Type. Print)

12

20a. Method of Disposition

21. Signature Funeral Service

23a. Part1. Enter the disease, or shock, or heart failure. List

31. Date filed (Month, Day, Year)

**JUN 19** 

Immediate Cause (Final

resulting in death)

15. Decedent's Education (Specify only highest grade completed)

Janet Goodgion(Sister-In-Law)

1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

College (1-4or 5+)

M01458

**Examiner** 

**Funeral** 

Director

ral", or items 23a or 28a-f show Examiner must be notified at

"natural", or

and Mental Hygie Is marked other

f Health aitem 27 la

permit. Pages 1 Department of H Important: If ite any Injury or ot

Director

Funeral

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Completed

Be

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with the Maryland

death

within 72 hours after

Baltimore, Maryland 21215-0036

physician and s the burial-tran as attending I for use as signed by the a d be detached f within 24 hours after death

To the Funeral Director:

		Due to (or as a consequence ot):	
miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a consequence of):	
dical Exa	resulting in death) Last	Due to (or as a consequence of):	
nysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ♣ No 9 □ Unknown	23c. If yes, outcome pf pregnancy  1  Live birth 2  Fetal death 3  Ectopic pregnancy  4  Pregnant at time of death 5  Other (specify)  Month	very Day Year
Completed by Physician/Medical Examiner	Part II. Other significant conditions o	24a. Was an 24b. Were aut	obably 4 Unknown opsy findings available ompletion of cause of
e e	25. Was case referred to medical	26. Place of Death (Check only one)	
0	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other: 4   Nursing Home 5   Residence 6   Other (Special Property of the Control of the C	ify)
TION:	27. Manner of Death 1   Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year)  28b. Time of Injury 28c. Injury at Work?  28d. Describe how injury occurred	
) er illic	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Run City or Town, State)	ral Route Number,
Medical Certification:		ysician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as inner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due and manner stated.	
M	29b. Signature and title of certifier	29g. License number 29d. Date signed (Month)  29g. License number 29d. Date signed (Month)	
	30. Name and address of person who	D-18545 JUNE 18 completed cause of death (Item 23a) (Type, Print) U.D., 12070 OLD LINE CENTER WAYDUF,	Idd. 2000

DHMH 17 Rev 1/2001

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month 4:35 P.M 13, Ronald Wayne Snyder June 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery 12148 Suffolk Terrace Gaithersburg 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthdav) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days Months Hours Director 196-34-7719 63 June 2, 1944 PΆ Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r 28a-f show notified at 1 ☐ Yes 2 X No Directo Maryland | Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? a or ms 23a must b 12148 Suffolk Terrace 20878 United States death Funeral "natural", or Items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 X Yes 2 No 1962 - If Yes, Give Year or Dates: 1968 1 and 2 should be filed within 72 hours after 1 Never Married Married altimore, Maryland 21215-0036 1 ☐ Yes 21K No <u>≽</u> Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation the Medical 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed v
Department of Health and Mental Hygie.
Important: If item 27 is marked other it
any injury or other traumatic event, the Heavy Equipment Operator Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ည Pau1 Κ. Snyder Elizabeth Mae Lambert 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Snyder/Wife 12148 Suffolk Terrace, Gaithersburg, MD. 20878 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cem. 6/18/2007 | Silver Spring, MD. 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr., Gaithersburg, MD. 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acate Myslogenous
Due to (or as a consequence f): **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): P.O. Box 68760, IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death Day Year 5 Other (specify) ed by the a detached f 9 Unknown ate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, \$ Myelodysplatic 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate 2**X** No 1∐ Yes funeral director 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 ☐ Nursing Home 5 🖾 Residence 6 ☐ Other (Specify) ٩ this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After Hospital or Attending 24 hours after death. 5 ☐ Pending investigation 1X Natural 2 Accident 1 ☐ Yes 2 ☐ No To the Hospital or Attend within 24 hours after death To the Funeral Director: 3 Suicide 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number M DOG 0335 MO 20+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Drive # 327 18111

State Registrar

Prince

Year)

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 3 per doc 9869 7-13-07 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Deeth Day 2007 В. Selsky June 16, Sarah 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Shady Grove Adventist Hospital Montgomery Rockville If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
Dec. 5, 19 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 1 ☐ M 2 ☐ F 200-03-4994 1912 Russia Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐Yes 2 ☐ No Maryland Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20854 U. S. A. 11213 Fall River Court 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 1 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2**X** No Specify: White Specify: 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Years Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pesach Black Ida Mottsman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paula Greenwald - Daughter 11213 Fall River Court, Potomac, Maryland 20854 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3X Removal from State King David Mem. Gdns 6/19/2007 Falls Church, Virginia 4 Donation 5 Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility Edward Sage Fruneral Direction, Inc. 1091 Rockville Pike, Rockville, Maryland 20852 Donald 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Day'S Immediate Cause (Final CVA disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): IF FFMALE: If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 🏋 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 4 Unknown 2 No 3 Probably 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 24 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurred

**Physician** /Medical Examiner

**Physician** 

Examiner

**Funeral** 

Director

28a-f show

items 23a or

permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23s any Inluy or other traumatic event, the <u>Medical Examiner must once.</u>

Baltimore, Maryland 21215-0036

Examiner must be notified at

Director

Funeral

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Completed

Be

2

the Maryland

/Medical

and the burialphysician attending p ass signed by the has certificate has ij within 24 hours after death

To the Funeral Director:
completely filled in by the

Examine Physician/Medical Completed by To Be

Medical Certification:

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

25. Was case referred to medical 1 ☐ Yes 2X No 27. Manner of Death

1 X Natural

2 Accident

4 Homicide

(Check only

3 ☐ Suicide

5 Pending investigation

6 Could not be determined

28a. Date of Injury (Month, Day Year) 28b. Time of Injury

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? M

1 □ Yes 2 □ No

28f. Location (Street and Number or Rural Route Number, City or Town, State) Ecritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier un

29c. License number 64853 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9901 Medical Center Drive, Rockville, Maryland Dr. Hassan Aumaira

31. Date filed (Month, Day, Year) JUN 19 2007 32. Registrar's Signature

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** 200 Edward Smith Robert /Medical 4c. County of Death 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) Examiner NICEMICO ledical Lenter Alisbury eninsula If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number **Funeral** Days Hours 1**X** M 2□ F 59 Director 220-52-0057 8/21/1947 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 XYes 2 No Director Wicomico Salisbury Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21804 USA Funeral Jerome Drive Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 ☐ Yes 2 X No white Specify: Completed by Baltimore, Maryland 21215-003 3 Widowed 4 Divorced Army 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 12 Dispatcher Perdue Farms 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Kathleen Marie Gordy Edward Harvey Smith မှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1616 Wilton Rd., Petersburg, VA 23805 Donald L. Smith/brother 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Wicomico Memorial Park 1 → Burial 2 □ Cremation 3 □ Removal from State 6/18/07 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 21. Signature of Funeral Service Licensee Jarra 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner death certificata be executed signed by the attending physician and dbe detached for use as the burial-trar 68760 at Physician/Medical Box IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy Month Day Year 5 ☐ Other (specify) P.O. 1 □ Yes 2 □ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 2 No 3 Probably peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No has page 2 To the run.
within 24 hours after death.

To the Funeral Director: After this certificate I

"nomoletely filled in by the funeral director, pag 1☐ Yes Division or Vital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2000 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 1 🕅 Inpatient P 27. Manner of ath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury Certification: (Month, Day Year) Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No € ☐ Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide 29a. Certifier Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 106 MilfORI 31. Date filed (Month, Day, Year) gistrar's Signature 32. State 2007

Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month James Andrew Shearman 0335 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Dorchester Dorchester General Hospital Cambridge If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Yes 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 1 M 2 □ F 1934 Missouri **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Maryland Dorchester Cambridge 1 ☐ Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21613 **USA** 3 Bay View Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? Black, White, etc. 1 es 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☐ No þ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Customer Service Account Manager Publishing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lola Stout Abbott V. Shearman 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3 Bay View Avenue, Cambridge, MD 21613 Betty L. Shearman/Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Important: If It any Injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Trappe, Maryland 4 ☐ Donation 5 ☐ Other (Specify) White Marsh Cemetery 6.19.2007 S gnature of Funeral Service Licenses 22. Name and Address of Facility Curran-Brottiwell Funeral Home, 308 High St., Cambridge, MD Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final vilure 246 Be Completed by Physician/Medical Examiner

Physician /Medical **Examiner** 

Baltimore, Maryland 21215-0036

attending physician and for use as the burial-transit

within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dire within 24 hours a To the Funeral L

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician:

Sequentially list conditions.	b. Due to or as a conservence of):	5420		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		opic pregnancy er (specify)		ate of delivery Ionth Day Year
	contributing to death but not resulting in the underly	ying cause given in Part I.		ntribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown
			24a. Was an 24b. autopsy performed? 1 Yes 2 2 10 Yes	Were autopsy findings available prior to completion of cause of death?  1 ☐ Yes 2 ☐ No
25. Was case referred to medical examiner?		26. Place of Death (	Check only one)	
1 Yes 2 No	Hospital: 19 Inpatient 2 ☐ ER/Outpatient 3	□ DOA Other: 4 □ Nursing Home	e 5 ☐ Residence 6 ☐ Ot	her (Specify)
27. Manner of Death 1: ■Natural 5 □ Pending 2 □ Accident investigatio	28a. Date of Injury (Month, Day Year)  28b. Time of Injury	28c. Injury at Work?	d. Describe how injury occu	rred
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		actory, office 28	f. Location (Street and Num City or Town, State)	ber or Rural Route Number,
29a. Certifier 1 Sertifying Pl (Check only 2 Medical Exa	invsician: To the best of my knowledge, death occ miner: On the basis of examination and/or investi- and manner stated.	urred at the time, date and place, an gation, in my opinion, death occurred	d due to the cause(s) and m I at the time, date and place	nanner as stated. , and due to the cause(s)
29b. Signature and title of certifie		29c. License number	29d. Date sign	ed (Month, Dav. Year)

1)26388 June 15 2007 Type, Print) 307 Celling Hurlock md 21643

State Registrar

Certification: To

Medical

Michael 31. Date filed (Month, Day, Year)

nd address of person who completed cause of death (Item 23a) (Type, Print) Adde

32. Regis

MD

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month John Edward Titus /Medical Jun 16, 2007 7:25 P 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Millennium Health & Rehabilitation Center Edgewater Anne Arundel 7. Age (In yrs. last birthday) 5. Social Security Number If Under 1 Year | If Under 24 Hrs 6. Sex Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 □ F Director 219-16-1900 90 Maryland May 27, 1917 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ " any hijury or other traumatic even." 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director Calvert Prince Frederick 1 ☐ Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 85 Central Drive 20678 U.S.A Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 X No Specify: Black 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 3 Farmer Farming 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Jacob Titus Kizzie Jones ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phillis Claggett /Cousin P.O. Box 62 Owings, MD 20736 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 06/21/07 Huntingtown, MD Patuxent UM Church Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Islady a. Sewell Funeral Home 1451 Dares Beach Road Prince Frederick, MD 20678 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner ovascular disease extensive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last u to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-tran and Due to (or as a consequence of) attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a Wasan autopsy performed? Yes 2 No Confestive Heart 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation

Division or Vital Records, P.O. Box 68760. or Attending Physician: After this death. within 24 hours after death To the Funeral Director: in by t the Hospital

State Registrar

Medical

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

6 ☐ Could not be

determined

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number D 50653

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 Yes

29d. Date signed (Month, Day, Year) 6-18-2007

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SURANA GYAN . C.

Deale Churchten Deale

31. Date filed (Month, Day, Year) JUN

32. Registras Signature 20 2007▶

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** М Donald Warren Truslow, Sr. 2007 2034 13. June /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Union Hospital of Cecil County Ceci 1 E1kton 8. Date of Birth (Month, Day, Year) April 26,1944 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days Months 1 M 2 □ F 215-42-5205 63 Maryland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City. Town or Location 10d. Inside City Limits ns 23a or 28a-f show must be notified at 1 ☐ Yes 2 TNo Maryland Cecil North East 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21901 342 Old Bayview Road, Apt. No. 7 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11 Marital Status Black White etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 6 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify. ğ 3 Widowed 4 Divorced White 'natural", 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Town of Port Deposit Elementary/Secondary (0-12) Nine Years College (1-4or 5+) Maintenance Port Deposit, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 27 is marked of traumatic ever Frank W. Truslow Gaverella Snelling ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any Injury or other tra Donald W. Truslow, Jr. (son) 1157 Rock Springs Rd., Conowingo, Maryland 21918 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State R.A. Ferris & Co., Inc. 06/21/07 West Chester, Pennsylvania 4 □ Donation 5 □ Other (Specify) 21. Sign are of Funeral Service Licensee 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, P.A. 100 Perryville, Maryland 21903-0766 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ordroc orrest disease or condition resulting in death) /Medical ue to (or as a consequence of): **Examiner** Examine Physician/Medical signed by t I be detach þ Completed Be

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760 After

in 24 hours the Funeral Dire

Certification:

Medical

State Registrar 31. Date filed (Month,

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  C. Due to (or as a consequence)  Due to (or as a consequence)  d.	-
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown  23d. Date of delivery Month Day	Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of the ca	Unknown
24a. Was an autopsy finding prior to completion of death?  24b. Were autopsy finding prior to completion of death?  1 Yes 2 No 1 Yes 2 No	s available cause of
25. Was case referred to medical examiner? 26. Place of Death (Check only one)	
Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)	
27. Manner of Death 1 Natural 5 Pending 2 Accident Accident Accident Sala Date of Injury 28a. Date of Injury (Month, Day Year) 28b. Time of Sala Date of Injury 28b. Time of Sala Date of Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred	
3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of injury - At home, farm, street, factory, office City or Town, State)	ımber,
29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause and manner stated.	(s)
29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year,	2

DHMH 17 Rev 1/2001

To the

Cokso

gon, MO 223 WMain St. Elkhon, MO

who completed cause of death (Item 23a) (Type, Print)

Orden

### 07-04482

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Douglas Tuckhorn,			ate of	Marylar	nd / Depar	rtment of	Healt	n and	Menta	al Hyg	iene	5 N	9 4	Ou	7 2151
	Do	For State gistrar Decedent's Name (First, Middl	a Last)		Cen	ilicate of	Deau			2.	Date of D			3.	Time of Death
Physician/ Medical Examine		Douglas Dennis		khorn,	Jr.						Month June 11		7		1807 hrs
		. Facility Name (if not institutio	n, give str	eet and num			4b. City, T		ocation of	Death		ľ	4c. County of De Prince Geo		
		Prince Georges Hospi			. Age (In yrs. Ia:	et hirthday)	Cheve	r 1 Year	If Under	24Hrs.	8. Date of	Birth (M	M/DD/YYYY) 9.	_	
Funeral Director	5.	Social Security Number 215-31-1868	6. Sex		2. Age (III yrs. Ia		Months		Hours	Min	Foreig			reign	try) DC
Director		sual Residence of Decedent	1 X M	2 F	21 113.					11	riay	1,	1700		
any	_	Da. State 10b. County			10c. City,	Town or Local	ion								0d. Inside City Limits Yes 2 XNo
<b>*</b>		Maryland Montg	omer	у	Ge	ermanto						100	Citizen of What		
to 28a-f sh iffed at once	1	De. Street and Number	1				10f. Zip	2087	76			1 - 3	United		
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5-0036 lied within 72 hour lygiene. t other than "nate the Medical Ex.		7. Father's Name (First, Middle	Last)			DITEC						dle, Maio	den Surname)		
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212 ould b d Menu s mard	۶ <u>۲</u>	9a. Informant's Name/Relation				19b. Maili	ng Address	(Stree	t and Num	ber or Ru	ural Route	Numbe	r, City or Town, nantown ,	State, 7	Zip Code) 20876
Baltimore, MD 21215-0036  permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene other than "matural", or items 23a or 28a-f sho Important: If item 27 is marked other than "matural", or items 23a or 28a-f sho injury or other transmatic event, the Medical Ex miner must be notified at once.	- 1	Nancy Gibson	(M	other		Place of Dispo				erra	Date Date		Oc. Location - C		
or Heal of Heal of Heal In the International		20a. Method of Disposition  1 X Burial 2 Crematic	n 3	Removal fr	om State	crematory or o	ther place	:)		June	$50^{16}$ ,		Germant	owr	ı, MD
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Physician	+	Signature of Funeral Service Licensee 22. Name and Address of Facility DeVol Funeral Home, 10 E. Deer Park Drive, Gaithersburg, MD 20877  a. Fart Nerie the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset and Between Onset and													
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Division of Vital Records, P.O. Box 6876C To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the b	Medical	(Check only one) 2 Medical I	xaminer:	on: yo the basi and manner	s of examination	and/or inves	tigation, in	my opinio	on, death	occurred	at the time	e, date a	and place, and d	ue to ti	ne cause(s)
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Registrar

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D.	1 and Health em 27 other tr		20a. Method of Disposition		20b. F	Place of Dispo	sition (Name o	f	ace, i	Date			r Town, State	
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	-		23a. Part1. Enter the disease, or c shock, or heart failure. List o	omplications that only one cause on e	caused the deat	th. Do not ent	ter the mode of	dying, suc	ch as cardiac	or respiratory a	rrest,	•	Approxim Interval B	etween
F	Physician		Immediate Cause (Final disease or condition	а Нурс	xia								Onset an	d Death
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0	eath c attenc for us	ian/	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live I	tcome pf pregna birth 2 ☐ Feta nant at time of d	al death 3	☐Ectopic pregn ☐ Other (specif				23	3d. Date of d Month	elivery Day	Year
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, ·	s that ned b e deta	by Pł	Part II. Other significant condition	s contributing to d	eath but not res	ulting in the u	nderlying caus	e given in f	Part I.	23e. Did	tobacco us	se contribute	to the cause of	f death?
cords,	en sig	ed b	Rhabdomyolysis							1 🗆	Yes 2	]No 3□	Probably 4	Unknown
ב ע	law re as be 2 sho	plet								24a. Was		24b. Were	autopsy finding completion o	s available cause of
ב ו	The cate h	Completed								perfo 1□ Yes	ormed? 2 <b>1</b> No	death′ 1 ☐ Ye	?	
N I G	ician: certific ector,	Be	25. Was case referred to medical examiner?	Hospital:				26. Other:	Place of Dea	th (Check only	one)			
5	Phys	-T	1 ☐ Yes 2X No 27. Manner of Death	28a. Date	Inpatient 2 ☐	ER/Outpatier 28b. Time o		41	☐ Nursing H	ome 5 Resi			necify)	
5	Attending r death. ector: After by the fune	tion	1 X Natural 5 ☐ Pending 2 ☐ Accident investiga	(Mor	nth, Day Year)	Injury	М	Injury at Work? 1 ☐ Yes	2 🗆 No		,,	,		
	Atter r deal ector by the	ifica	3 Suicide 6 Could no 4 Homicide determin	Zoe. Place	e of injury - At he	ome, farm, sti	reet, factory, of	fice		28f. Location (	Street and wn, State)		Rural Route N	umber,
5	tal or s afte al Dir ed in	Certification:	4 Entoniede	build	ing, etc. (opecin	197				Ony or 10	wii, Otate)			
	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death.  within 24 hours after death.  completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director.		(Check only 2 Medical E	Physician: To the k	asis of examina									e(s)
	thin 2 the or the or th	Medical	one)  29b. Signature and title of certifie	and man	iner stated.		29c. Li	cense num	nber		29d. Date	e signed (Mo	nth, Day, Year	)
1	F ≥ F 8			WUM	Mex	MO		6 <b>357</b> 9				ne 18,		
F	12+1	- 3	30. Name and address of pers, n w	no completed cau	of death liter	m 23a) (Tvpe.	Print)							
		9. 1	Maria Tayag, M.					ilver	Sprin	ng, MD 2	0910			
	Sta Registr		31. Date filed (Month, Day, Year)	2007	egistrar's Signa		rasti i							

DHMH 17 Rev 1/2001

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Month Helen Marie Tull 1825 M 2007 /Medical Pacility Name (If not inetitution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death ENINSULA KEGIONAL MEDICAL LENTER ALISBURY Wiczmico If Under 1 Year | If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1 □ M 2**K** F Hours 217-28-3928 75 Director Aug 20,1931 MD Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits show r 28a-f show notified at Funeral Director 1 Yes 2 No MD Worcester Snow Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? d other than "natural", or items 23a or event, the Medical Examiner must be a 105 E. Federal St. 21863 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No 3altimore, Maryland 21215-0036 ģ Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Hotel Maid 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be or other traumatic Sidney R. Fisher Maggie Foreman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carole Corbin/daughter 4306 Tower Dr., Snow Hill, MD 21863 20b. Place of Disposition (Name of cametery, crematory or other place)
Williams A.M.E.
Church Cemetery

22. Name and Ad ress of Facility 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any Injury or 4 ☐ Donation 5 ☐ Other (Specify) 6/16/2007 Newark, MD 21. Signature Funeral Service Licens Lewis N. Watson Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 3 day /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or Division or Vital Records, P.O. Box 68760, Physician/Medical monte attending ph for use as t IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ do 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 No death? 1 □ Yes 2□ No 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No Certification: To 1 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mann∍ of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After t 28c. Injury at Work? 1 atural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No after death 2 Accident filled in by the 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the within To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

4904

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

JUN 15 2007

ternando

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



, Md.

6-13-07

			State of Maryland / Department of Health and Men  - State Registrar	ntal Hygien Reg. N	e	21515
	Physicia	an	1. Decedent's Name (First, Middle, Last)	Date of Death Month Da	ay Year 3 2007	3. Time of Death
	/Medic Examin		HCWARA  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	-	c. County of Death	
	Lxaiiiii		PENINSOLA REGIONAL MEDICAL CENTER SALISBURY		Nicomes	
	Funeral Director		ZZI-ZC-0897 IMM 2 F 74 Yrs. Months Days Hours Min.	Date of Birth (Month, Day, Year 1 - 14 -	Cou	place (State or Foreign ntry)
	w and		Usual Residence of Decedent         10a. State         10b. County         10c. City, Town or Location	<u>,</u>		10d. Inside City Limits
	with the Maryland a or 28a-f show t be notified at	tor	MARYLAND Wicomico Salisbury			1 XYes 2 No
	th the or 28a e notif	irec	10e. Street and Number 10f. Zip Code	10g. C	itizen of What Cou	-
1	death with the Maryland ems 23a or 28a-f show r must be notified at	ral	1114 BRYN MAWR DR 21804	v Voc or No	US A	
ruit 36	s after i', or ite	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married  12. Was Decedent U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rica It Yes, Give Year or Dates: 95 1 Yes 2 No Specify:	an, etc.)	Black, White	
7-00-2	d 2 should be filed within 72 hours after than Mand Mental Hygiene. 7 Is marked other than "natural", or ite traumatic event, the Medical Examine	Completed I	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b.	Kind of Business/I	ndustry
721	within iene. than the Me	dmo	Elementary/Secondary (0-12) College (1-4or 5+)  1 Z  LADGRER		NONE	
200	be filed Ital Hygi d other event, t	BeC	17. Father's Name (First, Middle, Last)  18. Mother's Name (Fi	irst, Middle, Maide	en Surname)	
100	should b and Ment marked umatic e	2	DAMAS WISON RUITT ETHEL  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural R	GIR!	or Town State 7	in Code)
7 Howa	s 1 and 2 should f Health and Mer item 27 Is marke other traumatic		19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural R  1114 BRYN MAWR DR	Sale	hueu. M	1 11804
	is 1 and 2 of Health item 27 other tra		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)		Location City or	Town, State
D-C	Page ment c ant: If ury or		1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)  Md VA. CEME ERY 6-20	and the same of th	luelocks	Md.
737-30-089	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra		21. Signature of Funeral Service Licensee  22. Name and Addr is of Facility  41. Signature of Funeral Service Licensee  22. Name and Addr is of Facility  42. Libst Rd SAIISI	buey, 1	nd 2180	Home
23			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the dode of dying, such as cardiac or reshock, or heart failure. List only one cause on each line.	espiratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  Due to (or is a consequence of):			
3	Examiner		MRSA lower extremity ulcers			
. 3	p #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		- 31	
13	icate be executed physician and s the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last c			
7 PZ	sician buria	dical E	d .			
27 C	rtificate ng phy as the	Medic	The second secon		1	
# 231	. 0 00	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of deli Month	ivery Day Year
Δ	that the led by detac	/ Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
7	quires an sign uld be	q pe	Bladder Mass	1 ☐ Yes	2 No 3 Pr	obably 4 Unknown
Division or Vital Booords	e law re has bee	Completed by	ASCVD	24a. Was an autopsy performed	prior to	topsy findings available completion of cause of
5	in: Th ificate or, pag	Co	PVD  25. Was case referred to medical  26. Place of Death (	performed 1 Yes 2 K Check onlone	No 1 ☐ Yes	2 □ No
, i	ysicia ysicia is cert directo	To Be	examiner?  1   Yes 2   No		6 □Other (Spe	cify)
2	ng Ph ffer th	L :uc	11k Natural 5 ☐ Pending (Month, Day Year) Injury Work?	d. Describe how in	njury occurred	
	ttendil death. stor: A	icati	2 Accident investigation M 1 Yes 2 No 3 Suicide 6 Could not be 28e Place of injury 4t home farm street factory office 28f	f. Location (Street	and Number or Ri	ural Route Number,
	after din by	Certification:	4 Homicide determined building, etc. (Specify)	City or Town, St	tate)	
	e Hospita 124 hours e Funera letely filler	Medical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	nd due to the cause d at the time, date	e(s) and manner as and place, and due	s stated. e to the cause(s)
	To th withir To th Comp	Me	29b. Signature and title of certifier  29c. License number  40057 410		Date signed (Mont	th, Day, Year)
	6 mg					
	St Regist	ate rar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Simona Eng 100 E. Carroll St, Salisbury, md. 21  31. Date filed (Month, day, Year)  JUN 15 2007  32. Begistrar's Signature			

07-04493 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene **UNK UNK** 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Time of Death Physician/ Month Day June 12, 2007 Lachrisha P. Williams 0005 hrs **Medical Examiner** 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Suitland Prince George's 4641 Lamar Drive 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 5. Social Security Number If Under 1 Year If Under 24Hrs. 6 Sex **Funeral** oreitwashington, D.C. 577-92-8926 Months Days Hours Director 32 March 5, 1975 Yrs M 2 X F Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Suitland Maryland Prince George's 1 Yes 2 No iant: If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once. Director 10f. Zin Code 10g. Citizen of What Country? 10e. Street and Number 20746 U.S.A. 2649 Shadyside Avenue #T-3 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Black, Armed Forces? White, etc. 1 X Never Married Married 2 X No Yes Black more, MD 21215-0036
Pages 1 and 2 should be filed within 72 hours after near of Health and Mental Hygiene. Divorced If Yes, Give Year Yes 2X No specify: Specify: à 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired)
Unemployed Elementary/Secondary (0-12) College (1-4 or 5+) Nane 7th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Diame Williams Gregory M. Williams Be 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2649 Shadyside Avenue #T-3 Suitland, Maryland 20746 Baltimore, MD Dianne Williams (Mother) 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State June 22, 2007 Landover, Maryland Harmony Memorial Park 4 Donation 5 Other Specify nature of Funeral Service License 22. Name and Address of Facility Rollins Funeral Home, INc. 4339 Hunt Place. N.E. Washington, D.C. nat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Approximate Interval Part I. Enter the disease, or complications **Physician** Between Onset and Death failure. List only one cause on each line /Medical a Stab Wound of Chest Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed and Physician/Medical attending physician for use as the burial UNPENDED AMENDED O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Live birth Fetal death Month Day 4 Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown g Unknown the . detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Yes 2 ✓ No 3 Probably 4 Unknown Completed Division of Vital Records, been 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of icate has l performed? death? certificate ✓ Yes 2 2 No 1 🗸 Yes To the Hospital or Attending Physician: within 24 hours after death,

To the Funeral Director: After this certifi 26.Place of Death (Check only one) 25. Was case referred to medica funeral director, Be Hospital: Other<sub>4</sub> DOA Residence 6 🗸 Other: Scene Inpatient 2 ER/Outpatient 3 Nursing Home 5 1 ✔ Yes 28a. Date of Injury (Month, Day, Year) FOUND: 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Subject stabbed FOUND: Natura Yes 2 V No Pending in by the Jun 11, 2007 2351 hrs 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) (Found) 4641 Lamar Drive, Suitland, MD filled determined (Specify) (Found) Yard 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E June 12, 2007 He 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Ana Rubio MD. Assistant Medical Examiner Date filed (Month 32. Registrar's Signature State

DHMH 17 Rev 1/2001 **OCME 2006** 

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amend 4b-c, perMD, C870, 8/20/07 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JUNE 18, **Physician** 2007 LEROY WELDER ISAAC 2:00A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PRINCE GEORGE HOSPITAL PRINCE CEORGE Cheverly CHEVERLY Prince George's If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Days Months Hours 170-26-4554 1 ☑ M 2 ☐ F PENNSYLVANIA 74 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Director MD PRINCE GEORGE LANDOVER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7215 KENT TOWN DR 20785 Funeral death A • 4. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene.
Is marked other than "natural", or Itel 1 Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 2 □ No Specify: WHITE 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MECHANIC PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be ౖ CLIFFORD WELDER FAYE HARTZFELD Department of Health an.
Important: If item 27 is m. any injury or other 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ETHEL A. WELDER/WIFE 7215 KENT TOWN DR. LANDOVER, MD 20785 20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 3 DRemoval from State 4 □ Donation 5 □ Other (Specify) MD NATIONAL CEMETERY 06-21-2007 LAUREL, MD 21. Signature of Funeral Service License 22. Name and Address of Facility JB JENKINS FUNERAL HOME 7474 LANDOVER RD LANDOVER, MD 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** CONGESTIVE HEART FAILURE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CORONARY ARTERY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner be executed ATHEROSCLEROSIS use as the burial-tran Due to (or as a consequence of) Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) P.O. | been signed by the a should be detached 1 Tyes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by PERIPHERAL VASCULAR DISEASE 1 Yes 2 No 3 Probably 4 Unknown RENAL FAILURE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page perform 2 No OLD STROKE 1□ Yes 2X No director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မှ 1X Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury 28b Time of 28d. Describe how injury occurred Injury at Work? After Certification: (Month, Day Year) 1 Natural 5 Pending investigation To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident the f 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 1/2001

State

3001 HOSPITAL DR CHEVERLY, MD 20785

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KHALID ASHAI MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 6/14/2007 Year **Physician** Bessie Waller 1:20AM M /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fasily Name Alend estitution air steet and pureber Examiner Prince George's Southern Maryland Hospitol Clinton If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** 1□ M 2√X 97 Yrs Virginia 225/14/6335 2/7/1910 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10a. State 10c. City. Town or Location 10b. County show r 28a-f show notified at txxes 2 □ No Director Md Capital Hights Prince George's 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number r than "natural", or Items 23a or the Medical Examiner must be 4328 Will Street 20743 USA Funeral Race - American Indian Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② VIO If Yes, Give filed within 72 hours after 1 □ Never Married 2 □ Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Specify: Black δ 3€Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) 6th College (1-4or 5+) Housewife Domestic Pages 1 and 2 should be filed vent of Health and Mental Hygie ant: If Item 27 Is marked other? 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last, Be Whittie Thorton Sussie Bowe ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2::
Department of Health at
Important: If Item 27 Is
any Injury or other trau Ceveal Thomas, Daughter 4328 Will St Capital Hights Md 20743 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 → Burial 2 → Cremation 3 → Removal from State Ft Lincoln Cem 6/20/2007 Brentwood, Md 4 □ Donation 5 □ Other (Specify) 21. Signature at Puner 1 Survice License 22. Name and Address of Facility Taylors Funeral Home 1722 North Capital St NW Washington DC 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. CARDIOVAKLULA DIS Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): be executed and Due to (or as a consequence of): Box 68760, physician Physician/Medical the as attending use 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal dea 4 Pregnant at time of death 2 Fetal death 3 ☐ Ectopic pregnancy Month Day Year for in the past 12 months? 5 Other (specify) ☐Yes 2 XNo P.0. the 9 Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, <u>Ş</u> 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☐ No 24a. Was an autopsy performed? Yes 2 No has page 2: certificate 1 | Yes director. 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA ဥ this funeral 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After t Certification: To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After (Month, Day Year) Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Ja e

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

12070

and address of person who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

CENTER WALDENF, Md. 28602

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 2007 Willard 20 John. W lne /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University of Manyland
5. Social Security Number 6. Sex Medical lenter Baltimore 8. Date of Birth (Month, Day, Year) Jan. 22, 19 Birthplace (State or Foreign Country) **Funeral** Hours 1 X M 2 □ F 218-38-0942 66 Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the M-dical Examiner must be notified at any injury or other traumatic event, the M-dical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐Yes 2 No Directo Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15207 National Pike Apt.I 21740 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Heavy Equip. Operator Stone Quarry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Roy Wilford Willard Anna Mae Brunner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia A. Willard - Wife 15207 National Pike Apt. I Hagerstown,MD 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5 ☐ Other (Specify) 4 Donation Smithsburg Crematory 06-22-2007 Smithsburg, Maryland 21. Sign were of Funeral Servi 22. Name and Address of Facility Osborne Funeral Home, P.A. 425 S.Conococheague St. Williamsport, MD 21795 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Gastrointestina /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed physician and the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy perform 1□ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No P 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide the Hospital 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) June 20 2007 1747 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 216-5 Greene Street, Baltimore MD 21231 Wemine 22 South MD State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		ļ	1 = For State Registrar		epartment of Health and I	Mental Hygie	7 11 17	21521
-	Physici		1. Decedent's Name (First, Middle, L Steven Andrew			2. Date of Death Month 06/12/2	Day Year	3. Time of Death 4:18 A M
	/Medic Examin		4a. Facility Name (If not institution, g Prince Georges	rive street and number)	4b. City, Town, or Location of Death Cheverly	1	4c. County of Deal Prince (	h
	Funeral Director		5. Social Security Number 6. 257-70-9291	Sex 7. Age (In yrs. last birth	day) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye March 31	ear) Co	hplace (State or Foreign buntry)
1.0	ס		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town	or Location	Har en 5	41747	10d. Inside City Limits
	Maryli a-f eho	tor	MD Prince	Georges Captio	ol Heights			1X Yes 2 □ No
	or 284	Director	10e. Street and Number		10f. Zip Code		Citizen of What Co	ountry?
	e 23e	erai	7918 Beechnu	1t Street 12. Was Decedent Ever in U.S.	20743		SA 14. Race - Ame	erican Indian.
036	2 should be filed within 72 hours atter death with the Maryland and Mental Hygene. Is marked other than "netural, or Iteme 23s or 28s-f ehow aumatic event, the Madrial Exaction remails and filed at	by Funeral	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	Armed Forces?	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 1 ☐ Yes 2 ☑ No Specify:	o Rican, etc.)	Black, White Specify Bla	e, etc.
15-0036	"netur	Completed	15. Decedent's (Specify only highest of	Education 16a. [	Decedent's Usual Occupation Give kind of work done during most of wor life. DO NOT use retired)	rking 16t	o. Kind of Business	Industry
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ם	be filed tal Hygie d other event, the	Be	17. Father's Name (First, Middle, La			ne (First, Middle, Mai	den Sumame)	
Maryland	d Mental marked o	ပ္	Earl McQuary  19a. Informant's Name/Relationship		Mailing Address (Street and Number or Ru	McQuary	ity or Town, State.	Zip Code)
	nd 2 salth an 27 to r			lams/Daughter 79	-		-	
Baltimore,	permit. Pages 1 and 2 should by Department of Health and Menta Important: If item 27 is marked eny injury or other traumatic engine.		20a. Method of Disposition  1 🗆 Burial 2 🌠 Cremation 3	□Removal from State 20b. Place of I cemetery.		Date 200	. Location - City or verdale	Town, State
<u>=</u>	artmer ortant injury		4 □ Donation 5 □ Other (Special Signature of Funeral Service Lice	uny)	22. Name and Address of Facility		ASHING	
Ã	Depa fmpo eny i		Frit C.	nderson	DUNNY SONS 56	SE EADS 5	T. NE.	20019
ng en <sup>er</sup>			shock, or heart failure. List on					Approximate Interval Between Onset and Death
	Physician / Medical		Immediate Cause (Final disease or condition resulting in death)	a. Non - Small	1 cell comer	as the	rang	
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Box 6	eath certifica attending ph for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	3 DEctopic pregnancy		23d. Date of de Month	livery Day Year
o.	thet the de led by the a detached t	hysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 □ Pregnant at time of death 9 □ Unknown	5 Other (specify)			
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l Records,	The law requete has been page 2 shouk	Completed				24a. Was an autopsy performer	prior to death?	utopsy findings available completion of cause of
Vita	ician: Sertific ector,	Be	25. Was case referred to medical examiner?	Hospital:		ath (Check only one)		
ō	Phys or this oral dir	oz :r	1 ☐ Yes 2 ☑ No  27. Manner of Death	28a. Date of Injury 28b. Ti	me of 28c. Injury at	fome 5 ☐ Residence 28d. Describe how		ocify)
ion	Attending Physician: r death. sctor: Atter this certition by the funeral director, I	ation	1 Natural 5 Pending 2 Accident investigat	tion	M 1 ☐ Yes 2 ☐ No			
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	To the Hospital or Attending Physician: The within 24 hours elter death. To the Funeral Director: Atter this certificate his purpletely tilled in by the tuneral director, page	Medical C		Physician: To the best of my knowledge, caminar: On the basis of examination and and manner stated.				
	within comple	ž	29b. Signature and title of certifier	llu	29c. License number		Date signed (Mon	
}	(4)		missing	/ <del>-</del>	D00549	61 2	June 12	1500.4.
2	40		Ar. Justin K	no completed cause of death (Item 23a) (1	Type, Print) Wisconsun Gr	e Suite	107 Bet	hesda UD
100	Sta Registi		31. Date filed (Month, Day, Year)  JUN 2 0 2007	32. Registrar's Signature	w w			

			For	State of Marylan				lental Hyg	iene	
			1 - State Registrar		Cer	tificate of	Death		eg. No.	7 21522
ı	Physici	an	Decedent's Name (First, Middle, La	_				2. Date of Deat Month	Day Year	3. Time of Death
	/Medic			ard		4h Ciby Town o	r Location of Death	June 1	4c. County of Dea	4:45
	Examin	er	4a. Facility Name (If not institution, give							
-	Funeval		Holy Cross Hosp: 5. Social Security Number 6.5	Sex 7. Age (In yrs.	last birthday)		If Under 24 Hrs.	8. Date of Birth	Montge 9. Bir	thplace (State or Foreign
	Funeral Director		218-92-7038	1□ M 2□XF 43	Yrs.	Months Days	Hours Min.	(Month, Day, April 20		ountry) Maryland
	pr ,		Usual Residence of Decedent		y, Town or Lo	nation				10d. Inside City Limits
	arylaı show	-	10a. State 10b. County	10c. Git	y, TOWN OF LO	cation				1 ☐ Yes 2 ☐ No
	the M 28a-f otifie	Director	Maryland Monto	gomery Wh	neaton	10f. Zip Code		1	Og. Citizen of What Co	
	with the r		2719 Terrapin	Road		2090	6		US.	
	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or items 23a or 28a-f show imatic event, the Medical Examiner must be notified at	Funeral	11. Marital Status	12. Was Decedent Ever in U.	.S. 13. \		lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	14. Race - Ame	erican Indian,
က္	or iter	Fur	1 X Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give		fYes, specify Cuba 1 □ Yes 2⊠ No	an, Mexican, Puerto  Specify:	Hican, etc.)	Black, Whi Specify: Wh	· ·
03	ral", c	l by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:		TEL 165 ZENINO	Зреспу.		Specify: WII	
5-0	72 h 'natu dical	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	i (Give	tent's Usual Occup kind of work done DO NOT use retired	during most of work		16b. Kind of Business	/Industry
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9	filed v Hygie ther i		17. Father's Name (First, Middle, Las.		I Nev	VET WOLKE	18. Mother's Nam	e (First, Middle, I		
au	ld be ental ked o	To Be	William M. Ward				Theresa	S. Mahai	ney	
Maryland 21215-0036	should band Ment s marked umatic e	-	19a. Informant's Name/Relationship	(Type. Print)	19b. Mailir	ng Address (Street	and Number or Ru	ral Route Number	; City or Town, State,	Zip Code)
Σ	and 2 salth a n 27 is		William M. Ward,	III/Brother	13107	Beaver_	Terrace,	Rockvil:	le, Maryla	nd 20853
ore	of He		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐	/	Place of Dispo cemetery, crer	sition (Name of natory or other plac	ce) Jı	ine 18,	20c. Location - City or	Town, State
Ē	Pag ment ant: I	6	4 □ Donation 5 □ Other (Special	ify) Met		tan Crem		2007	Alexandria	, Virginia
Baltimore,	permit. Pages 1 and 2 should by Department of Health and Ments Important: If Item 27 is marked any Injury or other traumatic evonce.		21. Signature of Funeral Service Lice	- Auffrein	Fr		Collins		Home Inc. ilver Spri	ng, MD 20901
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that caused the deat	h. Do not ent	er the mode of dyir	ng, such as cardiac	or respiratory arr	est,	Approximate Interval Between
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8760,	cate be executed physician and the burial-transit	dical		d						
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0	ne dea the a	/sic	1 ☐ Yes 2 🕱 No 9 ☐ Unknown	4□Pregnant at time of c 9□Unknown	death 5	Other (specify) _				,
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or Vital Records,	Physician: r this certific ral director,	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1X Inpatient 2 □	]ER/Outpatier	nt 3□ DOA Oth	ner: 4  Nursing H	ome 5 Resid	ence 6 □Other (Sp	ecify)
	ng Pl		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28c. Inju Wor	ry at rk?	28d. Describe h	ow injury occurred	
sio	Attending r death. ector: After by the fune	catic	2 Accident investigation 3 Suicide 6 Could not I	1			Yes 2 □ No			
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	Hospital 24 hours a Funeral I tely filled		29a. Certifier 1 <sup>™</sup> CertifyIng P	Physician: To the best of my kno	owledge, deat	h occurred at the ti	me, date and place	, and due to the o	ause(s) and manner a	as stated.
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	edical		aminer: On the basis of examina and manner stated.						
	To the within 2 To the complet	Me	29b. Signature and title of certifier		-	29c. Licens		2	9d. Date signed (Mor	
	6		Muni	= MD-		D32	1332		June 15	, 2007
	X		30 Name and address of person who				000 5::			002
	//		Suresh K. Gupt			a Avenue,	220, Si	ver Spr	ing, MD 20	902
	Sta Regist		31. Date filed (Month, Day, Year)	2007 32. Registrar's Signa	ature	hereis				

	1	State of Maryland / Department of Health and N  1- State Registrer Certificate of Death		ene 2007	21523
Physiciar		1. Decedent's Name (First, Middle, Last)  Fdog Worrell	2. Date of Death Month	Day Year	3. Time of Death
/Medica		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	June	4c. County of Death	
Examine		Dorchester General Hospital Cambridge		Dorch	ester
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hs. Months Days Hours Min.	(Month, Day,	Year) 9. Birth	place (State or Foreign intry)
Director		メ) ラー/ (Gー ) みよ/ Usual Residence of Decedent	May 30	1926 IV	aryland
ehow	1	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 1   Yes 2 No
us after deeth with the Mar ai', or teeme 23e or 28e-fel is printed must be mutilled	2	MD Dorchester Cambridge  108. Street and Number  107. Zip Cool	10	g. Citizen of What Cou	
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er des	nu a	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 ☑ Marned 1 □ ∀es 2 ☑ No	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
5-0036 72 hours aft natural; or	ý	3 Widowed 4 Divorced Year or Dates:		Specify: 6/	ack
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2121 ad within giene. er than	dillo	Elementary/Secondary (0-12)  College (1-4or 5+)  Housewife		own Hon	e.
re, Maryland 21215-0036  1 and 2 should be filed within 72 hours after death with the Marylar Health and Mantal Hygiene.  1 the 23 is marked other than "natural", or iteme 23s or 28s-1 show other treumetic event. The Medical Examiner must be mutilied at	B	17. Father's Name (First, Middle, Last)  18. Mother's Name  19. A control of the			_
Maryland de should be file th and Mental Hy I? is marked oth treumetic event	0	Fleetwood Lercy Pinder Alice  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rur.	TOOGOC ai Route Number,	od Wate City or Town, State, Z	r5 ip Code)
Mand 2 sand 2 sand 2 sand 2 sand 2 sand 127 is		James Robert Worrell 608 Greenwood Ave.	and the second	•	MD. 2/6/3 Town, State
		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)	Date		Town, State
Baltimore bermit. Pages 1: Depertment of He important: If item any Injury or oth	-			ambridge	Maryland
Dermi Depermine impo impo		21. Signature of Funeral Service Licensee  Janelle C. Denry  Henry Funeral Ho.  510 washington St	COMBY	idge, Ma	ry land 21613
		23a. Panty/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory arre	est,	Approximate fnterval Between Onset and Death
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Cords	0	Emphysema, pulmonary embolism	1 <b>□</b> /Ye	s 2 No 3 Pro	obably 4 DUnknown
Division of Vital Records, to Attending Physicien: The law requirest after death. Director: After this certificate has been signed in by the funeral director, page 2 should be to a stall of the stall	aldu .		24a. Was a	v prior to d	topsy findings available completion of cause of
f Vital Reystrien: The is certificate his director, page		25. Was case referred to medical 26 Place of Deat	111111111111111111111111111111111111111	No 1 ☐ Yes	2 No
of Vita Physicien: this certific ral director,	ם O	examiner?		nce 6 ☐Other ( <i>Spe</i> o	ify)
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Division O' To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	and due to the cared at the time, da	ause(s) and manner as ate and place, and due	stated. to the cause(s)
To th within To th compli	3e	29b. Signature and title of certifier 29c. License number	2	9d. Date signed (Month	n, Day, Year)
	_	V CC CCC M.D. D50804		June 18	1000
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Mark Malkas, M.D. 408 Barn Street Com	Stille	MD 31613	2
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		1	For State	State of Maryland			nt of Health are			ene	American Commence of the Comme	21524	
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9	Funeral Director		230-52-8807	9X 7. Age (In yrs. ia ☐ M 200 F 71	Yrs.	Months	r 1 Year If Under Days Hours	Min.	8. Date of Birth (Month, Day, MAY 7 19	Year) 936	Cour	lace (State or Foreign htry) GINIA	
	and	+	Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	cation					1	0d. Inside City Limits	
	Maryl	ğ	MD PRINCE (	GEORGE'S D	ISTRI	ст н	ETGHTS					Yes 2 No	
	r 28a	iec	10e. Street and Number				p Code		10	g. Citizer	of What Cour	ntry?	
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9	within 72 hours after death with the Maryland ene. ttan "tatural", or Items 23a or 28a-f show its Madical Examinar must be notified at	y Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U.\$ Armed Forces? 1 ☐ Yes 2 █ No If Yes, Give		Was Dece If Yes, spe 1 ☐ Yes	dent of Hispanic Or ocity Cuban, Mexica 2 No Specify		ecify Yes or No- Rican, etc.)		Race - Americ Black, White, ecify:		
8	ural',	d by	3 XWidowed 4 □ Divorced	Year or Dates:	162 Dagg	dont's He	al Occupation			16h Kind	of Business/In	dustry	
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21215-0036	with iene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		KER				PRIV	ATE		
and 2	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 ahow amply injury or other traumatic event, the Madical Examinat must be notified at ance.	To Be C	17. Father's Name (First, Middle, Last) TUCKER LEE MERE						e (First, Middle, N Y DAVIS	Aaiden Su	mame)		
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Ħ	artme ortani Injury		21. Signature of Funeral Service Licen		DIRREC 22	2. Name a	nd Address of Faci	lity J.	B. JENI	CINS	FUNERA	L HOME	
Ba	Depa Impo any I			6		7474	LANDOVE	R ROA	D LANDO	VER,M	ARYLAN	<sup>D</sup> 20785	
À	Physician /Medical		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the death one cause on each line a.  Due to (or as a consequence)	m	ter the mo	de of dying, such a	s cardiac	or respiratory arre	est,		Approximate Interval Between Onset and Death	
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.O. Box	that the death certifical fed by the attending phy detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12;months? 1 ☐ Yes 2 € No 9 ☐ Unknown		Live birth 2 Fetal death 3 Ectopic pregnancy  Pregnant at time of death 5 Other (specify)				23d. Date of delivery  Month Day		•		
<u>α</u>	uires that signed by	۵	Part II. Other significant conditions of	contributing to death but not resu	underlying	John January and American State of the Control of t			id tobacco use contribute to the cause of death?  ☐ Yes 2 ANO 3 ☐ Probably 4 ☐ Unknown				
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ital		ВеС	25. Was case referred to medical examiner?				26. Pla	ce of Dea	th (Check only on			Depolten	
of V	A S	10	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatie	nt 3□ 0		Nursing H	ome 5 Reside		Other (Spec	M //8011	
	ff fer	on:	27. Manner of Death  1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o		28c. Injury at Work?	¬No	28d. Describe ho	ow injury o	occurred	710004.	
Division	or Attendition deat	Certification	2 Accident investigatio 3 Suicide 6 Could not b 4 Homicide determined	M treet, facto	1 ☐ Yes 2 [ ory, office		28f. Location (Si City or Town		Number or Ru	al Route Number,			
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	RX		30. Name and address of person who	completed cause of death (Item	23a) (Type	, Print)				-0		·	
_	- W		Michael J. LaPe			se H	ighway, A	nnap	olis, MD	2140	)1		
	St Regist	ate rar	31, Date filed (Month Car Year)	32. Registrar's rigna	W								

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 4 Time of Death Month JULY Catherine T. **Physician** Ashman 10:30MA 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Center Towson Baltimore 8. Date of Birth Aug. To Year) 922 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 213-12-8234 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** 1 □ M 2 🖸 F Months Days Hours Min. Maryland 84 Director Usual Residence of Decedent 10a. State 10c. City. Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important; If them 273 is marked other than "natural"; or items 23a or 28a-f show any hjurry or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes X☐ No MD Baltimore Parkville Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3010 Dubois Avenue 21234 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Year or Dates: | 16b. Kind of Business/Industry | Whiting and Turner 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Secretary Contractors 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Matthew Rosso Katherine Bauer ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3010 Dubois Avenue-Parkville, Maryland 21234 19a. Informant's Name/Relationship (Type. Print) Debra Ireton-daughter 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Holy Redeemer Cemetery 1 Burial 2 □Cremation 3 □Removal from State 7-7-07 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 8800 Harford Road 21. Signature of Funeral Service Licensee Parkville,MD 21234 Cendrai Y15 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician SEPSIS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed as the burial-transit and Due to (or as a consequence of): the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 □Ectopic pregnancy Month Day 5 Other (specify) 9 ☐ Unknows signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CLOSTRIDIUM DIFFICLE COLITIS 3 Probably 4 Unknown 1 🔲 Yes has been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ Mo CONGESTIVE HEART FAILURE 24a. Was an autopsy performe After this certificate Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one 2 100 Hospitai: Impatient 28a. Date of Injury Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Tes 2 ER/Outpatient 3 DOA 27. Manner of De 1 Natural 2 Accident 28b. Time of funeral 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Injury 5 ☐ Pending investigation daath. 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Hospital 29a. Certifier 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year)

Division or Vital Records, P.O. Box 68760 within 24 hours after daath To the Funeral Director:

> State Registrar

31. Date filed (Month, Day, Year)

JUL 0 5 2007

BOON POH LIM,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



D 37254

MARYLAND 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month illiam amonte OCAM 007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Social Security Numb Hospice Centr Baltimore 1 cus If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Director ence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes 2 X No Director Columbia Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10706 Walh 21044 Funeral Orchage 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No ģ 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 295 OWner Paint Protection co 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) To Be h and Mental F is marked ott Pages 1 and 2 should be mc Clain illiam allie 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 i 100 Cordage Walk, Columbia mo 21044
Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1
Department of H
Important: If ite
any Injury or ot 1 Burial 2 □ Cremation 3 ☐Removal from State 4 Donation 5 Dother (Specify) unbig memorial 07.06 2007 Columbia mD
22. Name and Address of Facility Vangha C. Greene funcial Service 21. Signature of Funeral Service Licensee 23a. Part1. Entasthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 8718 Liberty Mid Mandellestam mo 21133 Approximate Interval Between Onset and Death Concer **Physician** disease or condition resulting in death) months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician: The law requires that the death certificate be executed burial-transit physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) ate has been signed by the page 2 should be detached 9☐Unknown g ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has autopsy performed? Yes 2 No 1□ Yes funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Dother (Specify) 1 | Yes 2 | 1 | No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 ☐ Pending investigation (Month, Day Year) 1 Natural neral Director: / 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and fittle of firtifier 29c. License number 29d. Date signed (Month, Day, Year) un

State Registrar JUL 0 5

DHMH 17 Rev 1/2001

V. Charles

30. Name and address of person who completed cause of death (tem 23a) (Type, Print)

32. Registrar's Signature

1 - For State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

hysicia/ Medic/	an	1. Decedent's Name	e (First, Middl A	AL	LAN				2.	Date of Deat Month	Day 20	200 F	3. Time of Deat
Examin		4a. Facility Name (/ Lorien N	f not institutio	n, give street a	nd number) ab Franl	kford	4b. City, Town	n, or Location of altimor			4c. Cou	nty of Deat	h
uneral rector		5. Social Security N 214-20-0	492	6. Sex 1 □ M 2√g		'In yrs. last birthday Yrs.	) If Under 1 Year Months Day		24 Hrs. 8. Min. 0	Date of Birth (Month, Day, 8/21/19	Year) <b>907</b>	9. Birtl Co	hplace (State or Foruntry)  MD
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or 28 De no	Funeral Director	10e. Street and Nu					10f. Zip Code	• 21236		1	0g. Citizen <b>US</b> /	of What Co	untry?
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 10c,17 per fh e869 7-5-07 vt. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JAMES Day Month Year **Physician** NDERSON 0.7 10 15 AM 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner evindale Nursins Home Daltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 2/19 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 218-16-Months 1 M 2 □ F Hours MD Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f show must be notified at Owings 1 ☐ Yes 2 ☐ M Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Sidebrosk Rd. 2111 USA Funeral Was Decedent Ever in U.S. Armed Forces?
1 ☐ es 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, th and Mental Hygiene. 7 is marked other than "natural", or iten traumatic event, the Medical Examiner 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. <u>ک</u> Specify: BIK 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Carrier 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Elmer Anderson Be Sane (Type. Print) (DCUSWIR) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21117 Side brook t of Health 5901 Owings Mills, MD
20c. Location - City or Town, State Rd. sanice other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date Department of Important: If it any injury or conce, 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 17/07 Eastern SHore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Veughn C Greene Funeral services BALTIMORE NOTIONAL Pike BALTIMOR MD 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician LUNG CANCER disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) law requires that the death certificate be executed attending physician and for use as the burial-transi Division or Vital Records, P.O. Box 68760, 6 Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by MCART TTILURE ONGESTIVE 1 ☐ Yes 2 ☐ No 3∄ Probably 4 □Unknown V (H) UMS MROMBUS, S 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 s autopsy performed? Yes 2010o After this certificate 1□ Yes or Attending Physician: director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 ANatural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated.

State

Registrar

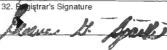
BARATUNDE 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) L ( ) ATC (

MYSICIAN

JUL 0 5



2434W.

**ORIGINAL** 

29c. License number

D0064533

BELVEOLRE

29d. Date signed (Month, Day, Year)

CTIZ

MD 21215

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BATTIMME

07

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Day **Physician**  $\mathbf{P}^{\mathsf{M}}$ Howell H. Billingslea 28 2007 2:52 June /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Towson Baltimore Gildhrist Center If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Nov 17, 1925 7. Age (In yrs, last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 M 2 □ F 215-20-7747 81 Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8820 Walther Blvd. 21234 Funeral USA within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Ongin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 □ Yes 2 No Baltimore, Maryland 21215-0036 Specify Specify: White 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PayRoll Clerk Maryland State RDS. comission permit. Pages 1 and 2 should be filed of Department of Health and Mental Hygic Important: If them 27 is marked other any Injury or other traumatic event \*\*\* 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marianna Albaugh Robert K. Billingslea sr. ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marianna Billingslea-Daughter 2 Commer CT. Timonium Maryland 21093 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Bunal 2 □ Cremation 3 □ Removal from State West Minster Cenetery July 3,2007 WestMinster Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 8800 Harford Road Parkville,Maryland 21234 evans funeral Chapel AND CREMATION SERVICES auciocans 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Dooth Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transi and law requires that the death certificate be execu Due to (or as a consequence of): P.O. Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) the 9□Unknown Š signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed' 1 Yes 2 No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DDA Other: 4 Nursing Home 5 Residence 6 QOther (Specify) 1 Yes 2 No ٩ To the Funeral Director: After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined hours after Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24

1041

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

6701

32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

Charles St. Bulto, Md 21204

07-04737

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Rob∈	ert William E		l-For State Registrar	ryland / Departmen Certificate			d Menta		Reg.	No.	200	7 0150
B& a d	Physici: ical Exami		1. Decedent's Name (First, Middle,Last)	morrow				N		ay	Year	3. Time of Death 0915 hrs
ivied	icai Exami		Robert William Budde  4a. Facility Name (if not institution, give street a			lb. City, Town, or	Location of I		ne 21, 200		nty of Death	
			3810 East Northern Parkway 3rd			Baltimore					N/A	
	Funeral Director		5. Social Security Number 219-56-4863 6. Sex	7. Age (In yrs. last birthda	y) Yrs	If Under 1 Year Months Day			Date of Birth( April15		Forcia	hplace (State or n <sub>untry)</sub> Maryland
			Usual Residence of Decedent	10c. City, Town or L								10d. Inside City Limits
	ow an		10a. State 10b. County Maryland N/A	Baltimor								1 XYes 2 No
	ryland a-f sh	흲	10e. Street and Number	Dateliloi		10f. Zip Code			10g	. Citizen o	of What Cour	itry?
3	he Ma or 28 iffed 2	Director	3810 East Northern P	arkway		21215				Unit	ed Sta	ites
_	after death with the Maryland 'al'', or items 23a or 28a-f sho iter must be notified at once	Funeral				s Decedent of His						can Indian, Black,
	death or iter must	ä	1	ned Forces? Yes 2 X No		es, specify Cubar		uerio Rica	in, etc.)		<sub>vify:</sub> White <sub>cify:</sub> Whit	
- 40 4 5 70	s after	<u>۾</u>	3 Widowed 4 X Divorced If Yes, Gor Dates  15. Decedent's Education (Specify only higher			Yes 2 No		nd of work	done I1		of Business/I	
	2 hour "nate	ted				ost of working life			done .	ob. Kina (	Ji Businessii	industry .
	036 ithin 7 ne. r than Tedica	Completed		N/A Co	ook					Eme.	rald I	avern
	21215-0036 Suld be filed within 7 Mental Hygiene, marked other than ic event, the Medica		17. Father's Name (First, Middle, Last)						st, Middle, Ma		ame)	
	121 Id be f fental narke event,	To Be	Herman Buddemeyer  19a. Informant's Name/Relationship (Type, Prin	t) 19b M	Mailing	Address (Stree			Bolcer		Town State	Zin Code)
	MD 2 nd 2 shou alth and N m 27 is n aumatic	F	Mrs. Shirley Stern (	·		,						21236 21234
	e, No. 1 and Health item		20a. Method of Disposition			ition (Name of ce		Da			tion - City or	
	imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Marelal Hygiene. Itani: If tiren 27 is marked other than "matural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at once.		1 Burial 2 X Cremation 3 Rem 4 Donation 5 Other Specify:	Evans E		eral Cha	apel '	June2	25,2007	For	est Hi	.11, Md,
×	Baltimore, MD 21215-0036 pennit. Pages I and 2 shouldbe filled within 72 hours Department of Health and Meinal Hygiene. Important: If tiene 27 is marked other than "natury injury or other traumatic event, the Medical Exami		21. Signature of Funeral Service Licensee		22. N Pe	lame and Addres aceful 1 25 York	s of Facility Alterna Road	ative Timor	es Fune	ral&@	Cremat	ion Ctr.P.A
	Physician		23a. Part I. Enter the disease, or complications failure. List only one cause on each line.	that caused the death. Do not en	nter t	ne mode of dying	such as car	diac or res	piratory arres	t, shock, c	or heart	Approximate Interval Between Onset and
	/Medical	i	Immediate Cause (Final disease a. Athe	erosclerotic cardio	ovas	cular dis	edSe					Death
			h	or as a consequence of):								
		ner		or as a consequence of):								
		ami	(Disease or injury that initiated events resulting in death) Last	or as a consequence of):			_	_				
M	cuted .(/	Ĕ	d									
	Division of Vital Records, P.O. Box 68760, It alor Attending Physician: The law requires that the death certificate be executed it as after death certificate be executed it as after death. After this certificate has been signed by the attending physician and Director: After this certificate has been signed by the attending physician and led in by the funeral director, page 2 should be detached for use as the burial - transit	edical Examiner	X UNPENDED X AMEN	ped b, perFH, 6869, 7/5	5/07	7 TT // 23	a,PII,2	7,perM	E,g869,	7/19/0	07 TT	
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	P.O. that the	by F	Part II. Other significant conditions contribu	iting to death but not resulting in	the i	inderlying cause	given in Part	I I.				the cause of death?
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	Re The Hificate T, Page	ပ်	25. Was case referred to medical			26 Plac	e of Death (C	Check only	1 Yes 2	No	1 🗸 Y	es 2 No
	/ital ysician ysician his cer directo	o Be	examiner?  1 ✓ Yes 2 No	1 Inpatient 2 ER/Outpa	atient		Othor	Nursing H		esidence	6 🗸 Othe	r: Scene
	of \ng Ph;	Ë	27. Manner of Death 28a	. Date of Injury (Month, Day,Year) 28b. Tim	ne of	njury 28c. Inju	ury at Work?	280	d. Describe ho	w injury o	ccurred	
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	Division of Vital Records, P.O. Box 6876 To the Hospital or Attending Physician: The law requires that the death certificat within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	Medical	one) 2 Medical Examiner: On the	he best of my knowledge, death basis of examination and/or inve								
	To wit	Mec	29b. Signature and title of certifier	nner stated.		29c. Licen	se number			29d. Date	signed (Mo	nth, Day, Year)
	30K		/ // /			0.0	.M.E.			June 2	2, 2007	
	PENDOME		//	d cause of death (Item 23a)		4 D S:	. D. III	- 100	04004			
	1			hief Medical Examiner		1 Penn Stree	t, Baltimo	re, MD	21201			
	S Regis	tate trar	31. Date filed (Month, Day, Year) 5 2007	32. Registrar's Signature	30	de						
			a a									

State of Maryland / Department of Health and Mental Hygiene.

For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 10:38A M JUNE 2007 30, KENNETH PAUL BURNETT, JR. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PRINCE GEORGES FORT WASHINGTON FORT WASHINGTON HOSPITAL If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
NORTH CAROLINA 8. Date of Birth (Month, Day, Year) MAY 09, 19 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1**XX**M 2□ F 1936 Director 577 50 1538 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County in than "natural", or items 23a or 28a-f show the Modical Examiner must be muffilled at 1XXYes 2 ☐ No PRINCE GEORGES CLINTON MD Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number UNITED STATES 20735 12803 APPLECROSS DRIVE Completed by Funeral filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? ☐Yes YNO Yes. Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes XXNo Specify: BLACK ₩Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) PRIVATE BRICK MASON 18. Mother's Name (First, Middle, Maiden Surname) traumatic event. 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill ment of Health and Mental Hiant: If item 27 is marked oth Be ADDIE LOUISE MILLER KENNETH PAUL BURNETT, SR. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trai once. 12803 APPLECROSS DRIVE CLINTON, MD 20735 VICKIE BANKS / SISTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition XXBurial 2 ☐ Cremation 3 ☐ Removal from State RUTHERFORDTON, NC JULY 7,2007 Donation 5 Other (Specify) NEW HOPE CEMETERY 22. Name and Address of Facility MARSHALL'S FUNERAL HOME OF MARYLAND, INC. 4308 SUITLAND ROAD SUITLAND, MD 20746 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock for heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CORCHANY ATHLOSCLENOTIC Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events The law requires that the death certificate be executed use as the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760, Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown 5 23e. Did tobacco use contribute to the cause of death? signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 3 Probably 1 ☐ Yes 2 ☐ No HYDERTENSION Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an D12050 autopsy 1 Tyes the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) √es 2 No 2 R/Outpatient 3 DOA Certification: To this After this funeral of 28a. Date of Injury (Month, Day Ye V) 28b. Time of Injury 28d. Describe how injury occurred Minner of Death 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident after death Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ģ 4 | Homicide /ο the within 24 hours the Funeral D' Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and tittle of certifier 07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FORT WASHINGTON, MD 20744 KINSE 11711 LIVINGSTON ROAD ROMALA 32. Pagistrar's Signature 31. Date filed (Month, Day, Year) State 0 5 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 16, 2007 JUNE /Medical 4c. County of Deati 4a. Facility Name (If not institution, give street and number) 4b. City Town, or Location of Death Examiner 9 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Director death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notifiled at 1 → Ves 2 □ No **Funeral Director** í 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Known AS CHAILES 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 12. Was Decedent Ever in U Armed Forces? Race - American Black, White, etc 11. Marital Status 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 ANO Baltimore, Maryland 21215-0036 1 ☐ Yes 2011No Specify: Completed by Specify. 3 ₩idowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surn me) Be ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S 1: ALTO. 20b. Place of Disposition (Na cemetery, crematory or 20a. Method of Disposition Date Pages 1 1 Burial 2 □ Cremation 3 ☐Removal from State TWE 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign tur Funeral Service L 23a. Part1. Enter the disease for c shock, or heart failure. List nplications that caused the dead Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** espena /Medical Due to (or as a consequence of): Examiner eman Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 2 No ate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed? Yes 24 No certificate 1 Attending Physician: To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 219 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

State Registrar

Medical

29b. Signature and title of certifier

MID

29c. License number

29d. Date signed (Month, Day, Year) 0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

821 N. EUTAW ST Soute 308 BALTIMOREMI) 21201 · WASHMI

1 retifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

31. Date filed (Month, Day, Year

29a. Certifier

32. Registrar's Signature

		For State Registrar	State of Maryland		t of Health e of Deatl			iene ( ) 7	21535
- All .	3	Decedent's Name (First, Middle, Last)					2. Date of Deat Month	th Day Yea	3. Time of Death
Physicia /Medic		Louise Brown	e Bayless	3			June 30	) <b>,</b> 2007	5:00 PM
Examin	_	4a. Facility Name (If not institution, give st		4b. City,	Town, or Location	n of Death		4c. County of De Prince (	_
		11006 New England			inton	ar 24 Hrs	8. Date of Birth		Sirthplace (State or Foreign
Funeral		5. Social Security Number 6. Sex 1□	7. Age (In yrs. ias M 2□xF 93	Yrs. Months			(Month, Day,	Year) 27 1913 No	orth Carolina
Director		Usual Residence of Decedent					Sept. 2	27,1719 10	
yland		10a. State 10b. County		Town or Location					10d. Inside City Limits
Mar-f	ctor	Maryland Prince Ge	orge	Clinton					1 ☐ Yes 2 No
th the	Funeral Director	10e. Street and Number		10f. Zij			1	log. Citizen of What	
23a	la l	11006 New Engla			20735	2 / 2 / 2	7	United	States merican Indian,
er deg	une Lu	11. Walla States	Was Decedent Ever in U.S. Armed Forces?	. 13. Was Dece If Yes, spe	dent of Hispanic ( cify Cuban, Mexic	an, Puerto F	Rican, etc.)	Black, W	
rs afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ሺ No If Yes, Give Year or Dates:	1 ☐ Yes	2∏No Specif	fy:		Specify:	White
thours af	ed	15. Decedent's Educ	ation	16a. Decedent's Usu	al Occupation			16b. Kind of Busine	ss/Industry
nin 7.	ple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	'life. DO NOT L	_	OSI OI WOIKII	9	0 7	
od with	Completed	12	4	Homem				Own H	ome
Viano  Suld be file  Mental Hy  arked oth  attic event	Be (	17. Father's Name (First, Middle, Last)			18. Mo			Maiden Sumame)	
Via ould Men Men Men Men Men Men Men Men Men Men	၉	George S. Brow		19b. Mailing Addres	- /Chant and Muse		y P. Wa		Zin Code)
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Heal Heal ther		20a. Method of Disposition	20b. Pla	ice of Disposition (Na	me of			20c. Location - City	
Saltimor  bernit. Pages Department of mportant: if it iny injury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	metery, crematory or e Cremator		2007		C1 i	nton, MD
ortan		21. Signature of Funeral Service License		22. Name a	nd Address of Fac	cility Lee	Funera	1 Home, I	nc.
Page 1		1/4 / 109/a	h novis	6633 (	old Alexa	andria	Ferry	Road Clin	ton ,MD20735
death certificate be executed  death certificate be executed  death certificate be executed  death certificate be executed  e attending physician and  death certificate as the buriat-iransit	al Examiner	23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque	ence of):  — PF fu					Approximate Interval Between Onset and Death 48件配
ificate g physias the	dlcal								
	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 [No 9 ☐ Unknown]	3c. If yes, outcome of pregnan  1 Live birth 2 Fetal of  4 Pregnant at time of deal  9 Unknown	death 3 ⊟Ectopic i				23d. Date of Month	delivery Day Year
- 2 D B	by Pt	Part II. Other significant conditions con				irt I.	1		e to the cause of death?  Probably 4 \(\sum \text{Unknown}\)
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Phys this ral dir	-T	1 ☐ Yes 2 No 27. Manny of Death	1 Unpatient 2 UE	R/Outpatient 3 C				dence 6 Other (	Бресігу)
ding After fune	ton	1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	Injury M	28c. Injury at Work? 1 ☐ Yes 2	□No			
DIVISION OF VITA To the Hospitel or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific; completely filled in by the funeral director,	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location City or							r Rural Route Number.
To the Hospitel within 24 hours a To the Funeral completely filled	edical	29a. Certifier 1 De tilying Physical (Check only one)	ner: On the basis of my knowner: On the basis of examinati and manner stated.	nledge Jeath contina ion and/or investigation	d at the time, dete in, in my opinion, o	and place, death occurr	and due to the e	cause(s) and manne date and place, and	r as stated. due to the cause(s)
o the lithin 2 o the	Med	29b. Signature and title of certifier	and manner stated.	2	9c. License numb	er		29d. Date signed (A	Ionth, Day, Year)
E 2 E 3		1 Les	an my		72	82	8-1	JULY :	2,2007
		30. Name and address of person who co		23a) (Type, Print)					
7		NELSON BEN	TOO C	Piscatawa	y Sui	te 600	, CLI	n Inach	20135
Sta	ate	31. Date filed (Month, Day, Year)	32 egistrar's Signat	ure					

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		- For State	Cer	tificate of D	eath	ai i iygii	Reg	. No.	265	1 2.153
Physiciai Medical Examin	n/	Decedent's Name (First, Middle,Last)			<u> </u>	N	late of Death	Day	Year	3. Time of Death 1520 hrs
oviedicai Examin o~	er	Forrest Leroy Boda. Facility Name (if not institution, give s	oser treet and number)	4b. (	City, Town, or Location of		une 26, 20		unty of Death	10201113
*		Bon Secours Hospital		В	altimore				N/A	
Funeral Director			7. Age (In yrs. la		Under 1 Year If Under flonths Days Hours	Min.	Date of Birth		Foreign	
	· ·	Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Location					Т	10d. Inside City Limits
* .	5	MD N/A			Baltimore					1 XYes 2 No
Maryla	Director	10e. Street and Number		10	of. Zip Code		10	-	of What Count	•
death with the Maryland or items 23a or 28a-f show must be notified at once.		1819 Dover Street	12. Was Decedent Ever in U.	9 13 Was D	21223 ecedent of Hispanic Origi	in? / Specify	Ves or No-		ed Sta	tes an Indian, Black,
eath w	Funeral	1 Never Married 2 X Married	Armed Forces?  1 Yes 2 X No	If Yes,	specify Cuban, Mexican,	Puerto Rica	an, etc.)		White, etc.	an Indian, Black,
after d	by F	3 Widowed 4 Divorced If	Yes, Give Year r Dates:		s 2 X No specify:				cify: Whi	
hours		15. Decedent's Education (Specify only Elementary/Secondary (0-12)	highest grade completed)  College (1-4 or 5+)		Isual Occupation (Give k of working life. DO NOT u		done	16b. Kind	of Business/In	dustry
136 thin 72 re, than '	Completed	8	College (1-4-01-5+)	Wate	er Works			Bal	timore	City
215-0036 be filed within 7 ntal Hygiene. -ked other than ent, the Medica		17. Father's Name (First, Middle, Last)					st, Middle, M	aiden Surr	name)	-
2121 2121 Duld be fi Mental I marked	Be	Henry Aldrich  19a. Informant's Name/Relationship (Typ	o Print \	10h Mailing Ac	dress (Street and Num	Anna (		or City o	r Town State	Zin Code)
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	٩	Mary Boser - Wif			Dover Street			-		2.p 000e)
re, N l and Health f item	1	20a. Method of Disposition  1 X Burial 2 Cremation 3		Place of Disposition crematory or other	n (Name of cemetery,	Da	ate	20c. Loca	ation - City or	Fown, State
Pages nent of ant: I		4 Donation 5 Other Specify;			Mem. Park	7-3-2	2007	Cri	sfield	, Maryland
Baltimore, ermit. Pages I ar Department of Hee Important: If iter njury or other tr	- 1	21. Signature of Funeral Service License	UW AI		e and Address of Facility	AHIDE C	se Fu	neral	Home,	Inc.
Physician	$\dashv$	23a. Part I. Enter the disease, or complic	ations that caused the death	. Do not enter the r	Hammonds France of dying, such as ca	rdiac or res	Lan	sdown st, shock,	or heart	21227 Approximate Interval
/Medical		failure. List only one cause on each	nine. Occlusive pulmona							Between Onset and Death
kaminer	- 1	or condition resulting in death)	ue to (or as a consequence o	f):	2.0-1-7					
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3760, ficate be g physici s the buri		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of preg  1 Live birth	nancy		pregnancy		23d. D. Mo	ate of delivery	ay Year
x 68 th certi	icial	past 12 months?	4 Pregnant at time of de	n a th	(Specify)	programicy				ay rour
Division of Vital Records, P.O. Box 68 tal or Attending Physician: The law requires that the death certifiers after death.  al Director: After this certificate has been signed by the attending led in by the funeral director, page 2 should be detached for use as.	Physician	1 Yes 2 No 9 Unknown Part II. Other significant conditions	g Unknown	conditing in the und	orlying cause given in Pa	<del>el</del>	23e Did to	hacco use	contribute to	the cause of death?
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rds, require been si	Completed						24a. Was a			topsy findings available ompletion of cause of
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risio r Atter ler deal irector n by th	licat	2 X Accident Investigation	c. 281	subject fell on ice  28f. Location (Street and Number or Rural Route Number, City						
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Division of Vital Records, P.O. Box 68: To the Hospital or Attending Physician: The law requires that the death certifit within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as the funeral director, page 2 should be detached for use as the funeral director.	Medical (	one) 2 Medical Examiner:	n: To the best of my knowled On the basis of examination a and manner stated.	dge, death occurred and/or investigation	at the time, date and pla , in my opinion, death oc	ace, and due curred at the	e to the caus e time, date a	e(s) and m and place,	nanner as state , and due to th	ed. e cause(s)
5.35.3	Re	29b. Signature and title of certifier	The Marie Country		29c. License number					nth, Day, Year)
9 3 nd		hij hi,	mp		O.C.M.E.			June 2	27, 2007	
or pena		-	dical Examiner 111	Penn Street,	Baltimore, MD 212	.01				
Sta Regist	ate rar	31. Date filed (Month, Day, Year) 5 21	32. Resistrar's Signat	ure Son	li)					

Physician /Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Division or Vital Records, P.O. Box 68760,

Examine

Physician/Medical

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Completed

Be မှ

Certification:

Medical

31. Date filed (Month, Day,

ron

**Physician** 

/Medical

Examiner

**Funeral** 

Director

ral", or items 23a or 28a-f show Examiner must be notified at

'natural", or

t: If item 27 is r

permit. Page Department o Important: If any injury or

Director

Funeral

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Completed

Be

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

within 24 hours after death

To the Funeral Director;

completely filled in by the

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23d. Date of delivery  Month Day Year	
PARKIN	ntributing to death out not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Unknown
924C	HACIA	24a. Was an autopsy autopsy performed?  1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No
25. Was case referred to medical examiner?	26. Place of Deat	th (Check only one)
1 Yes 2 No	lospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Ho	ome 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death 1 ☐ Ratural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)  28b. Time of Injury  28c. Injury at Work?  1   Yes 2   No	28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one) 1 Certifying Physical Exami	sician: To the best of my knowledge, death occurred at the time, date and place, ner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	, and due to the cause(s) and manner as stated. rred at the time, date and place, and due to the cause(s)
29b. Signature and title of Certifier	29c. License number D 5-1 7 28	3 29d. Date signed (Month, Day, Year) 7/3/2007

ROLLINGCROSSRAAD MD 21228

DHMH 17 Rev 1/2001

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State Registrar

0 State Registrar

31. Date filed (Month, Day, Year) 5 2007

KONSTANTIH ZUBELEVITSKIY 32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

900 CATON AVE. BALTIMORE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death June 30, 2007 Year **Physician** Mary Elizabeth Cooper 5:15 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1904 Medallion Court Forest Hill Harford If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. | 8. Date of Birth (Month, Pay, Year) Feb. 13, 1927 5. Social Security Number Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2 X F 185-20-2879 80 Pennsylvania Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Exeminer must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No MD Harford Director Forest Hill 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 1904 Medallion Court 21050 USA Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Completed by 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Internal Revenue Service Elementary/Secondary (0-12) College (1-4or 5+) IRS Agent 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ John Ramsey Eliza Elvin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1904 Medallion Court-Forest Hill,MD 21050 William Cooper-son 20b. Place of Disposition (Name of cemetery, crematory or other place)

IVY HILL Cemetery 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State Philadelphia, PA 7-6-07 4 Donation 5 Dother (Specify) 22. Name and Address of Facility
EVANS FUNERAL
AND CREMATION 21. Signature of Funeral Service Licer 8800 Harford Road CHAPEL 8800 Harford Road SERVICESParkville, MD 21234 tallier 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician 8 month /Medical Due to (or as a sequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9∏Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perforn 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA After thi funeral 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural s after deau. ral Director: Aftr 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours at To the Funeral C 29a. Certifiei 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 1/2001

State

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Registrar's Signature

Franklin Sg. Dr. St. 2200 Balto, MD. 21237

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death Time of Death 1. Decedent's Name (First, Middle, Last) Ruth May Collier **Physician** 9:33 PM June 30, 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Towson Gilchrist Hospice Center 8. Date of Birth (Month, Day, Year) Sept. 20, 1918 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Hours Months Days Min 1 □ M 2 X F 220-30-1580 Vienna, MD Director Usual Residence of Decedent 10c. City, Town or Location Parkville 10d. Inside City Limits 10a. State 10b. County 28a-f show ns 23a or 28a-f shov must be notified at MD Baltimore 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 3001 Edgewood Rd. 21234 death with USA Funeral 14. Race - American Indian, items ? . Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status i "natural", or items edical Examiner π Black, White, etc. e filed within 72 hours after of al Hygiene... I other than "natural", or iter 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 📉 No Baltimore, Maryland 21215-0036 Specify. ò 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Hospital Elementary/Secondary (0-12) College (1-4or 5+) Nursing 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 12 should be fill and Mental H Be Cyrus May Dora Ellis ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 625 Richewood Rd. Bel Air, MD 21050 Bernice Cox-Niece/ Guardian Department of Health a Important: If Item 27 Is any Injury or other tra 20b. Place of Disposition (Name of cemetery, crematory or other place)
Parkwood Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 7/5/2007 Parkville, MD 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) <sup>22. Name and Extense Furtheral Chapel & Cremation Services Parkville 8800 Harford Rd. Parkville, MD 21234</sup> 21. Signature of Funeral Service Licensee molal m & 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or, Examine burial-tran Due to (or as a consequence of): Box 68760, physician Physician/Medical the for use as IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4☐Pregnant at time of death 5 Other (specify) P.O. ed by the a detached f 9 Unknown signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 3 ☐ Probably 4 Unknown 1 ☐ Yes 2 □ No Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 2 this funeral 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of e Hospital or Attending Pl 24 hours after death. 9 Funeral Director: After t Certification: 28c. Injury at Work? After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2/ Accident the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely

5

State Registrar 31. Date filed (Month, Day,

0 5

29b. Signature and title of certifier

30. Name and address

tho completed cause of death (Item, 23a) (Type, Print)

and manner stated.

555 W.

29c. License number

Tawsentown Blud

29d. Date signed (Month, Day, Year)

Frances T. Childre	1	- For State	S	tate o	of Maryla	and / D		ment of icate of			Menta	i Hygi		leg. No.	20	07	2 1	) 4
Physician	1	Registrar 1. Decedent's Nam	e (First, Midd	lle Last)									Date of Dea		Year	3.	. Time of Death	
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Funeral	1	5. Social Security N		6. Sex		7. Age (I	n yrs. last t	pirthday)	If Unde	er 1 Year	If Under 2	24Hrs. 8	. Date of B	rth(MM/E			lace (State or	
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Hospi 24 hou Funer fely fil		29a. Certifier (Check only	Certifying	Physicia	ın: To the be	st of my k	nowledge,	death occu	rred at the	e time, da	ite and plac	e, and du	ue to the ca	use(s) ar	nd manner a	s stated	i.	
Division of To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After to completely filled in by the funeral	Medical	one) 2	Medical Ex		On the basis and manner		nation and/	or investiga				urred at ti	he time, da					
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		30. Name and add Carol Allan			ompleted cau nt Medical			<sup>3a)</sup> 11 Penn	Street,	Baltimo	ore, MD	21201						
Sta		31. Date filed (Mor	nth, Day, Yea		0.0		Signature	Acres	20			-						
Registr	ar		<del>JL 0 5</del>	2007	Hel	ice	J.	15/19/2										
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DHMH 17 Rev 1/2001 OCME 2006

07-04904 Willie Cooper Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1- For State Reg. No. Registrar 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day June 27, 2007 2340 hrs Willie Cooper Medical Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) NA **Baltimore City** Johns Hopkins Hospital If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Hours Months Country) 8-10-1971 Md. Director 35 213-80-5610 1 X M 2 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. Count 10a State 1 X Yes 2 No 23a or 28a-f show notified at once Baltimore Md. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number TISA 430 N. East Ave 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 12. Was Decedent Ever in U.S. 11. Marital Status White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 Married 2X No Yes or Specify: Black If Yes, Give Year Yes 2 X No specify: Divorced 3 Widowed 2 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Inc. College (1-4 or 5+) Flementary/Secondary (0-12) more, MD 21215-0036
Pages 1 and 2 should be filed within 72 lent of Health and Mental Hygiene. Atco Rubber Produce, Assember 10th grade 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Idella Logan Cooper, ir. Willie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21216 2812 Riggs Ave., Baltimore, Md. Idella Logan Mother 20c. Location - City or Town, State item 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition Baltimore, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Ξ 7-5-07 Randallstown, Md. King Mem. Pk. Important: injury or otl Donation 5 Other Specify 22. Name and Address of Facility 21. Signature of Funeral Service Licensee March F.H. East 21202 1101 E. North Ave., Baltimore, Md. Q ) ans 0 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Physician Between Onset and Death /Medical Intracranial henorrhage Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Ruptured ancurvsm Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Physician/Medical #23a-b.PII.27.perME.0869, 7/13/07 TT signed by the attending physician are detached for use as the burial. X UNPENDED The law requires that the death certificate be Box 68760, 23d Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy Day Year 23b. Was decedent pregnant in the 3 Ectopic pregnancy Fetal death past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions of Vital Records, P.O. Yes 2 No 3 Probably 4 V Unknown ⋧ Hypertension; drug use Completed 24b. Were autopsy findings available has been s 24a Was an prior to completion of cause of autopsy death? performed? 1 🗸 Yes 2 No ✓ Yes 2 certificate h 26 Place of Death (Check only one) Hospital or Attending Physician: 25. Was case referred to medical Be Other<sub>4</sub> examiner? Hospital: 1 ✓ Inpatient 2 Residence 6 Other Nursing Home 5 ER/Outpatient 3 DOA this 1 Ves No 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? After 27. Manner of Death Certification: 1 X Natural Yes 2 Division Pending within 24 hours after death.

To the Funeral Director:
completely filled in by the f Investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 3 Could not be Suicide determined (Specify) Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of cert O.C.M.E. July 1, 2007 or on who completed cause of death (Item 23a) 30. Name and address of per 111 Penn Street, Baltimore, MD 21201 Deputy Chief Medical Examiner Jack Titus MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 2007 Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend, item 31 per 19869 7-5-07 vt.
State of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** JANET Μ. COLGIER 6:15 PM JUNE 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Doctor's Hospital Lanham Prince Georges If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🕱 F 577-54-9003 68 03-03-1939 Washington.DC Director Usual Residence of Decedent 10c. City, Town or Location the Maryland 10a. State 10d. Inside City Limits 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at MD 1 X Yes 2 □ No Prince Georges Capitol Heights Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number with 6816 Drylog Street 20743 USA Funeral . 1 and 2 should be filed within 72 hours after death Health and Mental Hygiene. Health and Mental Hygiene. and 27 is marked other than "natural", or items 23 the fraumatic event, the Medical Examiner must 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: Black Maryland 21215-0036 1 ☐ Yes 2 X No Specify. þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Operations Specialist Gov't 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Payne Margaret Hawkins ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health a Important: If item 27 is any injury or other trauonce. Karen Wright Daughter 6816 Drylog Street Capitol Heights, MD 20743 Baltimore, Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Ft Lincoln Cemetery 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 06/26/2007 Brentwood, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licen Bianchi 814 Upshur St NW Wash, DC 20011 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician SPIRATORY disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner EFFUSIONS ATERAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be deteched for use as the burial-transit completely filled in by the funeral director, page 2 should be deteched for use as the burial-transit REAST ETASTATIC Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. O BSTRUCTION BOWEL Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 No 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 Probably 4 ☐⊌nknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an perform 2 1 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D61552 JUNE 21,2001 30. Name and address of person woo ompleted cause of death (Item 23a) (Type, Print) LANHAM, MD 201060 8118 4000 LOCK ROAS ERFAM 11.0 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

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Ty'Sha Denise M			artment of Health and Mental H	ygiene	2007 2154
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Funeral	-	. Social Security Number 6. Sex 7. Age (In yrs	last birthday) If Under 1 Year If Under 24Hr	s. 8. Date of Birth (MM/	DD/YYYY) 9. Birthplace (State or
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er de		1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year	1 Yes 2X No specify:	1247	Specify: BLACK
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21215-0036 nuld be filed within 7 Mental Hygiene. marked other than c event, the Medica		ANTHONY LEONARD CHAMBERS			
2121 uld be fi Mental marked	o Be		19b. Mailing Address (Street and Number or	A THUMASI	NA VIDA PORTER
	۲	19a. Informant's Name/Relationship (Type, Print )		•	21212
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F. Hearlife		Edd. Mostod of Disposition	crematory or other place)	Date 200.	Eccation - Sity of Town, State
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Baltimore, permit. Pages I an Department of Hea Important: If iter		21 Ignature of Funeral Service Licensee	22. Name and Address of Facility		
Department		13.	CALVIN B. SCRUG	GS FUNERA	L HOME
Physician	-	23a. Part I. Enter the disease, or complications that caused the de	ath/Do not enter the mode of dying, such as cardiac	or respiratory arrest, sh	TIMORE, MD 21212 lock, or heart
Medical		failure List only one cause on each line.	· ·		Between Onset and Death
xaminer			ed death in infancy		
		or condition resulting in death)  Due to (or as a consequence	e or):	13.	
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be ex within 24 hours after death.  To the Finneral Director: After this certificate has been signed by the attending physician completely filled in by the finneral director, page 2 should be detached for use as the burial.	ian/Med	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnant in the 1 Live birth	Petal death 3 Ectopic preg		Month Day Year
certi certi ndin	ciar	past 12 months?  4 Pregnant at time of	2		
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Division of Vital Rec within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, page	Certification:	4 Homicide determined (Specify) Single	e family residence	1834 N. Coll	ington Ave. Baltimore, Mi
losp 4 hor inne		29a. Certifier 1 Certifying Physician: To the best of my know	rledge, death occurred at the time, date and place, a	ind due to the cause(s)	and manner as stated.
To the Hos within 24 h To the Fur	<u>i</u>	one) 2 Medical Examiner: On the basis of examination	on and/or investigation, in my opinion, death occurre	d at the time, date and p	place, and due to the cause(s)
To To com	Medical	and manner stated.  29b. Signature and title of certifier	29c. License number		d. Date signed (Month, Day, Year)
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1 cro		Carot Hall	an		
Dry		30. Name and address of person who completed cause of death (I		204	
		Carol Allan, MD Assistant Medical Examiner	and the second s	4UT	
S	tate	31. Date filed (Month, Day, Year) 5 2007 32. Registrar's Sig	nature		
Regis	stra	111 0 9 - No. Johnson	- /		

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Taavon Javen Chambers

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		4a. Facility Name (if not institution 7207 Windsor Mill Rose)	-			ty, Town, or Lo ndsor Mill	ocation o	of Death		4c. County o		,
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2 H H E		20a. Method of Disposition		20b. Place o		Name of ceme		0,14	Date	20c. Location -	City or Tov	wn, State
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Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as			hysician: To the best of my									
To the Hos within 24 h To the Fur	Medical	one) 2 Medical Exa	miner: On the basis of exam and manner stated.	ination and/or ir	nvestigation, i	n my opinion,	death oc	ccurred at t	he time, date	and place, and o	lue to the c	cause(s)
T >F >	ž	29b. Signature and title of cortific				29c. License				29d. Date sign	ed (Month	, Day, Year)
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Li		30 Name and address of person						4D 0400	1			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death . Decedent's Name (First, Middle, Last) Year **Physician** 3:30 PM ONFER 2007 JUL 0 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE SAMARITAN HOPITAL N/A If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) April 30,1946 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Months Days 1□M 2**X**)F 207-36-8973 61 Pennsylvania Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if them 21 is marked other than "natural", or items 22 and any Injury or other traumatic event, the Marie any Injury or other traumatic event, the Marie any Injury or other traumatic event. 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 No Funeral Director N/A Baltimore Maryland 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number U.S.A. 21239 1548 Sherwood Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify ģ 3 Widowed 4 □ Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Health Care 12 Caregiver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Myers မ George Varner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia Beach, Virginia 23456 <u>Lori Partash</u> Daughter 1769 Turquoise Court 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify)

21. Sign \*tu\* of Fine \* I Service Licensee Hilltop Service Corp 07/03/2007 Towson 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. <u>1050 York Road</u> Towson, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to limited at cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit and Due to (or as a consequence of) physician Physician/Medical the attending properties of the second IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 3 □Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 🕱 No 4☐Pregnant at time of death 5 Other (specify) or Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ALWHOL TENCION, 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed certificate l 1 ☐ Yes 2 🛰 Vo 2 No director, Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 ☐ Yes 2 XNo 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA P this funeral 28a. Date of Injury (Month, Day Year) To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After t 1 Natural 5 Pending investigation 1 □ Yes 2 □ No 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier LXCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier thickel Kafrani JULY, 1, 2007 RESODO ELFROUNI, HIS MICHEL 30. Name and address of person who completed cause of death (flem 23a) (Type, Print)
600 b SAMARITAN HUSPITAL 560) LOCH RAVEN BIVY BALTIMORE HA 21239 32. Bigistrar's Signature 31. Date filed (Month, Day, Year) State JUL 0 5 2007 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend stam 10d per of he869 rtment 87 Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Franklin 30/2007 Crockett 0 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 2756 Winchester St. Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month. Day, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1**□**M 2□F 67 Yrs. Director Usual Residence of Decedent 10d. inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If tem 27 is americal other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at MD 1X Yes 27010 Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21216 2756 Winchester 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Yes 2 Is Yes, Give Year or Dates: 1 Never Married 2 Married BIK 1 Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) d 2 should be filed w th and Mental Hygier 7 Is marked other th 17. Father's Name (First, Middle, Last) Cherry Kobert John 19a. Informant's Name/Relationship (Type. Print) (Mother) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2756 Winchester St. Balts. MD. 2/216 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State bytys 7/4/07 Balto., MD

22. Name and Address of Facility us nn C Greene Funeral Sea.

5151 Balto. Nat'L P. Ke Balto. MD. Z1229 Arbutus 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses Balto. Nat'L P. Ke 5151 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) une Physician years /Medical Due to (or as a con equence of): **Examiner** Sequentially list conditions, if any, leading to initire diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dus to (or as a consequence of) be executed burial-transit Division or Vital Records, P.O. Box 68760,€ Due to (or as a consequence of): signed by the attending physician be detached for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown 1 □ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed2 1☐ Yes 2☐ No Hospital or Attending Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification; To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 25205 200/

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6

State Registrar

ORIGINAL

30. Name and address of person who completed cause of feath (Item 23a) (Type, Print)

N) A. K. L. J. G. Banc 6701 N. Charles St. Balts and 2020 >

32. Registrar's Signature

House

# Davis CharlesBaltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760, <

		Please Type or Print in Black In State of Maryland / Dep		•	•						
		_ FOF	ertificate of Death		Reg. No.	21548					
Physicia		1. Decedent's Name (First, Middle, Last)  Charles F Davis		2. Date of De Month July 4	Day Year	3. Time of Death 9:06A					
/Medic Examin	-	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	-	4c. County of Dea						
Francis		1554 Reinhardt Lane 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Glen Burnie ) If Under 1 Year   If Under 24 Hrs.	Anne Arunde l  24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign							
Funeral Director		217-38-5371 1√X M 2□F 67 Yrs.	Months Days Hours Min.	(Month, Da	y, Year)	ountry) WVA					
and w		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or L	ocation			10d. Inside City Limits					
Maryl -f sho fled at	tor	MD Anne Arundel Glen Burn				1 □ Yes 2 <b>∑</b> No					
or 28g	Director	10e. Street and Number	10f. Zip Code		10g. Citizen of What C	ountry?					
eath w		1554 Reinhardt Lane 11 Marital Status 12. Was Decedent Ever in U.S. 13	21060	ancifu Van ar Na	USA 14. Race - Am	erican Indian					
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentalle Hydiene. Important: If them 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status  1  Never Married 2 Married Amed Forces?  1 Never Married 2 Married Amed Forces?  1 Never Married 2 Married Amed Forces?  1 Never Married 2 Never Nev	. Was Decedent of Hispanic Origin? (SI If Yes, specify Cuban, Mexican, Puerton 1 ☐ Yes 2 ☑ Who Specify:	o Rican, etc.)	Black, Wh	te, etc.					
72 hou natura ical E	ted	15. Decedent's Education 16a. Dec	edent's Usual Occupation e kind of work done during most of wor	king	16b. Kind of Business						
ithin 7	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)	Kirig							
filed w Hygie other ti		12 17. Father's Name ( <i>First, Middle, Last</i> )	Driver 18. Mother's Nam	ne (First, Middle,	Logistic Maiden Surname)	CS					
uld be Aental rked o	To Be	William Davis		ne E. Char							
2 sho l and l is ma rauma		19a. Informant's Name/Relationship (Type. Print) 19b. Mail	ing Address (Street and Number or Ru			Zip Code)					
1 and Health em 27		20a. Method of Disposition 20b. Place of Disp	Reinhardt Lane, Glen I	Burnie, M	21060 20c. Location - City o	r Town. State					
Pages ent of nt: If It ry or o		1 ☐ Burial 2 ☐ Orther (Specify)  1 ☐ Burial 2 ☐ Orther (Specify)  Cemetery, charge in the state of the state	ematory or other place)	9, 2007	Baltimore, MI						
permit. Departm Importal any Inju			22. Name and Address of Facility Fink Funeral Home, P.								
80 E # 9	-	K Gregory Fink M01148	426 Crain Hwy S, Gler	n Burnie,		Approximate					
Physician		23a. Part Enter the disease, of con plications that caused the death. Do not enshoot, or heart failule. List only one cause on each line.  Immediate ause (Final disease or cindition			rrest,	Interval Between Onset and Death					
/Medical		disease or condition resulting in death)  a. Due to (or all a consequence of):	artery disease								
Examiner	e.	Sequentially list conditions, if any, leading to immediate b. Sue to (or as a consequence of).									
uted d ansit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.									
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eath certi attending for use a	Physician/Medic	III the past 12 months:	□Ectopic pregnancy □ Other (specify)		23d. Date of de Month	elivery Day Year					
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ysicfai s certii directo	To Be	25. Was case referred to medical examiner?  1  Yes  No  Hospital: 1 Inpatient 2 ER/Outpatie	26. Place of Dea	V	one) dence 6 □Other (Sp	acifu)					
ng Ph (fter thi		27. Manner of Death  128a. Date of Injury (Month, Day Year)  28b. Time (Injury			how injury occurred	Sony					
ttendi death. stor: A / the fu	icati	2 Accident investigation 3 Suicide 6 Could not be	M 1 ☐ Yes 2 ☐ No	28f Location /	Street and Number or F	Rural Pouto Mumbor					
tal or A s after al Dire ed in by	Certification:	4 Homicide determined building, etc. (Specify)	week, radially, office	City or Tox	wn, State)	urai Houte Number,					
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, p	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or in and manner stated.	ath occurred at the time, date and place investigation, in my opinion, death occu	, and due to the rred at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)					
To t To t	M	29b. Signature and title of certifier	29c. License number		29d. Date signed (Mor	th, Day, Year)					
8		30. Name and address of person who completed cause of heath (Item 23a) (Type Michael 240 COP) Edww	Print Slv.	1							
Sta Registr		31. Date filed (Month, Day, Year)  JUL 0 5 2007  32. Signature	hails ?								

DHMH 17 Rev 1/2001

			For	State	of Marylar		artment of H		and Me	ental Hy	giene	)			
		_ ]	State Registrar			Cei	rtificate of	Death			Reg. No.			21519	
Physi	iciar		1. Decedent's Name (First, Middle							2. Date of Dea Month JULY	Da			3. Time of Death 4:05 P M	
/Me Exan	dica	- 4	JULIA CLARK DAV  4a. Facility Name (If not institution)		number)		4b. City, Town, o	r Location o		JULI	01, 2007 4:05 P M 4c. County of Death				
Exam	IIIIIe		HOLY CROSS HOSE				SILVE	R SPR	ING			MONTGO	MER	Y	
Funera	al		5. Social Security Number	6. Sex 1 ☐ M <b>X</b> X F	7. Age (In yrs		If Under 1 Year Months Days	If Under 2	24 Hrs. 8 Min.	B. Date of Birt (Month, Da	rth 9. Birthplace (State or Foreign Country)				
Directo	or	-	238 16 2250 Usual Residence of Decedent	I N AAI	!	90 Yrs.			D	EC. 18	3, 1	916 NO	RTH	CAROLINA	
aryland show		-	10a. State 10b. County		10c. C	ity, Town or Lo	cation						100	d. Inside City Limits	
Mary a-f sh	3	200	DC		1	WASHING	TON							XX Yes 2 No	
th the or 28; e not	1	Director	10e. Street and Number				10f. Zip Code				10g. Cit	tizen of What	Country	y?	
ath wi			2501 18TH STREE				2001					JNITED			
er de Items	1000		<ul><li>11. Marital Status</li><li>1 ☐ Never Married 2 ☐ Marr</li></ul>	Armed	ecedent Ever in U Forces? s XX No	J.S.   13.	Was Decedent of H If Yes, specify Cub	lispanic Orig an, Mexican	gin? (Speci n, Puerto Ri	? (Specify Yes or No- uerto Rican, etc.) 14. Race - Ame Black, Whi					
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0 e s e			PEGGY HENSON /	DAUGHTER	1	2004	EAGLE LA	NDING	WAY	#203 O	DENT	CON, ME	21	113	
ges 1 and tof Health If item 27 or other to		Î	20a. Method of Disposition  XIX Burial 2 □ Cremation	2 Domoval from	- 1	Place of Dispo cemetery, crei	sition (Name of natory or other place	ce)	Da	te	20c. L	ocation - City	or Tow	n, State	
Pages ment of ant; If ite			4 ☐ Donation 5 ☐ Other (S	pecify)			L CEMETE		07/06			JITLAND			
permit. Pages 1 Department of H Important; If ite any Injury or ot	ouce.		21. Signature of Funeral Service	Licensee			Name and Addre IARSHALL 308 SUIT		ERAL I	HOME O	F MA	ARYLAND MD 20	,IN	[C.	
15 ST P			23a. Pa f. Enter the disease, or sh k, or heart failure. List	complications tha	t caused the dea		AT THE RESIDENCE AND ADDRESS OF THE PARTY OF						, A	Approximate nterval Between	
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To th withir To th comp	Mo		29b. Signature and title of certifie	<u>`</u>			29c. Licens	e number			29d. Da	ate signed (Mo	onth, Da	ay, Year)	
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2			30. Name and address of person			, , , , ,		C.	TIUED	CDDTx	· C	4D 2001	0		
V	State		RICHARD NGUYEN, 31. Date filed (Month, Day, Year)	1 00	Desistenda Cina	-4	GLEN RD	· D.	TLVEK	SEKTN	G, I	4D 2091	· U		
Regi		1	0 5	2007	Hegistrar's Sign	K A	and								

DHMH 17 Rev 1/2001

		For State Registrar		State of Ma	aryland /		artment of H			gien Reg. N		21550
the secret	sician		ame (First, Middle, La COrio	•	alenti	n			2. Date of De Menth June		ay 2007 <sup>Year</sup>	3. Time of Death 8:20PM M
	. Š.			nue	ə (İn yrs. last i	birthday) Yrs.	4b. City, Town, or Forestv: If Under 1 Year Months Days		8. Date of Bir	th ay, Year	r)   Cou	
D	36 ·	Usual Residence			10c. City, To		ocation Forestvil	10			OZEC	10d. Inside City Limits
iore, Maryland 21215-0036 gas 1 and 2 should be filled within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 271s marked other than "natural", or Items 23a or 28a-1 ehow	Funeral Director	10e. Street and 3007 S	Sydney Ave	nue	Ever in U.S.	13.	10f. Zip Code Was Decedent of Hi	spanic Origin? (	Specify Yes or No	I	Citizen of What Col	untry? rican Indian,
0036 nours after o	d by Fun	3 ☐ Widowe	arried 2 🙀 Marned d 4 □ Divorced	Armed Forces?  1  Yes 2  If Yes, Give Year or Dates:			If Yes, specify Cubai	Specify:	rto Rican, etc.)		Specify:	ite
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Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours all Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "nature!, or in the permit of the permi	ODC9.	4 Donatio	2 Cremation 3 Con 5 Other (Special Funeral Service Lice	(y)		rrec	tion Cemes 2. Name and Addres	tery 20	.ee Fune	ral	Clinton, Home, In oad Clint	•
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### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) Year **Physician** 04:17F M JOHN M. DAVIS Ø2, 2007 JULY /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Towson Saint Joseph Medical Center | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 01/16/1935 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** VIRGINIA 1**☆**M 2□ F 72 229-40-9797 **Director** Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County ms 23a or 28a-f shov must be notified at 1 ☐ Yes 2 No FREELAND BALTIMORE Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21053 1411 WALKER RD Pages 1 and 2 should be filed within 72 hours after death wont of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or items 23s Funeral 13. Was Decedent of Hispanic Origin? (Specity Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 7 is r a ked other than "natural", or items traur afte event, the Medical Examiner mu 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) ACCCUNTING 5+ ACCOUNTANT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be EVA MARIA SYDNOR EUGENE E. DAVIS ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1411 WALKER RD FREELAND, MD. 21053. KATHLEEN DAVIS(WIFE) Item 27 other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) = 5 Department o Important: If any injury or 07/06/2007 PARKVILLE, MD. PARKWOOD 21. Signature of Funeral Service Licenses HENRY W. JENKINS & SONS CO. 16924 YORK RD MONKTON, MD. 21111. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician CARDIAC ARREST /Medical Due to (or as a consequence of): Examiner MYOCARDIAL INFARCTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): physician ar Division or Vital Records, P.O. Box 68760, Physician/Medical the attending L IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autops, performed: 2 No 1□ Yes Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 1 Inpatient 2 KER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death After t Injury 5 ☐ Pending investigation 1 Natural 1 □ Yes 2 □ No 2 Accident hours after death uneral Director: 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed. (Month, Day, Year) 29b. Signature and title of certifier

15+1 State

31. Date filed (Month, Day, Year) 32.

M. D. 7601 OSLER 32. Adjistrar's Signature

ER DRIVE TOWSON, MARYLAND 21204

11 0 5 2007 Mayer & Spell

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

D39215

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ı	Physici		1. Decedent's Name (First, Middle, Last)  CAI VATORE PHILLIP	DINATALE 2. Date of Month	Death Day Year Old 2007 SUDAN M
	/Medic Examin		4a. Facility Name (If not institution, give street and number) BALTIMORE LEHABILITATION EX	4b. City, Town, or Location of Death	4c. County of Death
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda $216-16-1599$ $\frac{1}{M}$ $M$ $2\Box$ $F$ $82$ Yrs.	ay) If Under 1 Year If Under 24 Hrs. 8. Date of Month, March	Birth 9. Birthplace (State or Foreign Country) 1 15 1925 MD
	and and		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or		10d. Inside City Limits
	e Mary	ctor	MD Carroll Elders	burg	1 ☐ Yes 2 🎇 No
	23a or 24	Funeral Director	10e. Street and Number 2011 3B Rudy Serra Drive	10f. Zip Code 21784	10g. Citizen of What Country? USA
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Items 23a or 28a-f show says injury or other traumatic event, Ite Madical Establicational most approach.	Ď	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Amed Forces?  1 Never Married 2 Married Nover 1 Nov	Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.)     □ Yes 2√√√ No Specify:	No- 14. Race - American Indian, Black, White, etc.  Specify: white
21215-0036	ithin 72 ho ne. nen "natur Madical	Completed	(Specify only highest grade completed) (G	ocedent's Usual Occupation live kind of work done during most of working e. DO NOT use retired)	16b. Kind of Business/Industry
d 21	filed w Hygier other th	e Cor	17. Father's Name (First, Middle, Last)	ar salesman  18. Mother's Name (First, Mid	automotive  Idle, Maiden Surname)
Maryland	ould be Mental Arked carl	To Be	Alexander DiNatale	Mary Bisese	
Mar	and 2 shi alth and 127 is m er traum			ailing Address <i>(Street</i> and Number or Rural Route Nu 1 3B Rudy Serra Dr., Elde	
Baltimore,	Pages 1 ament of He tant; If item		1X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	sposition (Name of Date crematory or other place) hedral Cem. 7-9-07	20c. Location - City or Town, State Baltimore, MD
Ball	Depart Depart Import eny in		21. Signature of Funeral Service Licensee  Pary Jaight Stubert	P.O. Box 195 Sykesville	_
	Priysician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)	ry arrest, Approximate Interval Between Onset and Death	
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rds, P	w requires that been signed b should be deta		Part II. Other significant conditions contributing to death but not resulting in the	111/	old tobacco use contribute to the cause of death?
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on of	nding Phy th. : After thi s funeral	ıtlon: T	27. Manner of Death  1 X Natural 5 Pending (Month, Day Year) 2 Accident investigation	e of 28c, Injury at 28d, Descr	be how injury occurred
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	To the Hospital or within 24 hours after to the Funeral Director completely filled in I	edical (	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, description of the desired form of the des		
)	To the To the comp	M	29b. Signature and title of certifier  She A Hashmi MC	29c. License number 024648	29d. Date signed (Month, Day, Year) 07-04-2007
	3		30. Name and address of person who completed cause of death (Item 23a) (Ty) 5'HFRA HASHM) MD 3900	pe, Print)  DEH RAVEN BEVO	BALTIHORE 21218
	Sta Registr		31. Date filed (Month, Day, Year)  32. Begistrar's Signature	delis.	

07-04941	
Lori Dorsey	

ri Dorsey		I-For State	e of Maryland / I	Department <i>Certificate</i>		and Menta	ıl Hygiene	Reg. No.	007 215	5
Physicia edical Examir	n/	Registrar  1. Decedent's Name (First, Middle, L	ast)	0001			2. Date of I Month June 23	Death Day Yea	3. Time of Death 2109 hrs	
		4a. Facility Name (if not institution, Northwest Hospital	give street and number)	<del>2</del> 9	4b. City, To Randa	wn, or Location of D		4c. County of	of Death re County	
Funeral		<u>_</u>	Sex 7. Age (	In yrs. last birthday	) If Under	1 Year   If Under 2		Birth (MM/DD/YYYY		$\dashv$
Director	Ł	717 4 4 6 6 7 (4)	M 2 1	40	Yrs. Months	Days Hours	Min. 07/	24/1966	Country)	_
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safter de	by F.		ed If Yes, Give Year or Dates:	No 1		No specify:	M 301 1	Specify:	Black	_
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O등로드	۵	19a. Informant's Name/Relationship William Doese	y (Father)	196. Ma	31.3 F/	Whe Ru	er or Rural Houte	Number, City or Tow	7n, State, 2ip Code)	
tra da da		20a. Method of Disposition  1 Burial 2 Cremation	3 Removal from State	20b. Place of Dis crematory of	sposition (Name or other place)	of cemetery,	Pate	20c/Location	- City or Town, State	П
Baltimore, permit. Pages 1 a Department of He Important: If ite injury or other to		4 Donation 5 Other Spec 21. Signeture of Funeral Service Li		Lough	My Many Paper And A	deress of Facility	1/e/or	report sycs	more Will	
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lox 6876 cath certificate e attending phy for use as the b	Physician/M	past 12 months?  1 Yes 2 No 9 Unknown	9 Unknown		Other (Speci	fy)		-		
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J of Vi Jing Physi After this funeral dir	٤	1 Yes 2 No 27. Manner of Death	28a. Date of Injury (Month, Day,Yea	t 2 🗸 ER/Outpa		Bc. Injury at Work?	Nursing Home 5	Residence 6	Other:	_
Division tal or Attendir rs after death. at Director: A	cation	1 V Natural 5 Pendir 2 Accident Investi	gation		atarat fastas	1 Yes 2 1		ing (Chant and Numb	per or Rural Route Number, C	ie.
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Division of Vital Records, P.O. Box 6876 with Hospital or Attending Physician: The law requires that the death certificat within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending pheompletely filled in by the funeral director, page 2 should be detached for use as the	Medical C		sician: To the best of my iner:On the basis of exam							
To with	Med	29b. Signature and title of certifier	and manner stated.			License number		29d. Date sign	ned (Month, Day, Year)	
		10/01/01/	yell My	oth (No 02-1		O.C.M.E.		June 29, 2	2007	
2		30. Narhe and address of person w Melissa Brassell, MD	Assistant Medical I	Examiner 11		eet, Baltimore	, MD 21201			
Si Regis	ate trar	31. Date filed (Month, Day Year)	32 Registrar	s Signature	asse.					
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			- For Amend Item 24a,25	Marylan <b>per ve</b> i	d / Dep rb. <b>g86</b>	ortment of l 9.07/05/0 rtificate of	lealth and Death	d Mental Hy ا	giene 2 0   Reg. No.	97	21554
	Physici	an	Decedent's Name (First, Middle, Last)					2. Date of Dead Month June		Year	3. Time of Death
	/Medic			vans					28, 20	007	19:30 M
and the	Examin	er	4a. Facility Name (If not institution, give street and num Carroll Hospital Center	ber)		4b. City, Town, o	stminst		,	rol1	
	Funeral Director			7. Age (In yrs. i 86	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H	Hrs. 8. Date of Birt fin. (Month, Da May 15	h y, Year)	Cou <u>i</u> r	olace (State or Foreign
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	r 28a- notifi	Director	10e. Street and Number	<u> </u>		10f. Zip Code			10g. Citizen of W	hat Cour	ntry?
	th with 23a o 1st be		400 Daniel Drive			2	1157		USA	1	
	tems	Funeral	Armed For		S. 13.	Was Decedent of I If Yes, specify Cub	lispanic Origin? an, Mexican, Pi	? (Specify Yes or No- uerto Rican, etc.)	14. Race Black	- Americ	an Indian, etc.
36	irs afte	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes If Yes, Giv.  3 ☐ Widowed 4 ☐ Divorced Year or Da	5		1 ☐ Yes 2 📆 No	Specify:		Specify:	Wł	nite
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21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show ont, the Medical Examiner must be notified at	Completed	Elementary/Secondary (0-12) College (1	4or 5+)		kind of work done DO NOT use retire lerical	d)	, roming	Social	Soci	ıritv
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ılan	Mental rked c	To Be	Ralph E. Bennett				An	na L. (	Unknown)	)	
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e, P	1 and Health em 27		20a. Method of Disposition	20b. P	lace of Dispo	osition (Name of	-	Date	20c. Location - 0		own, State
E O	Pages Jent of Int: If I		1 M Burial 2 □ Cremation 3 □ Removal from 9 4 □ Donation 5 □ Other (Specify)	state Mor	emetery, crei gan Cl	matory or other pla nape1 Cen	etery 7	7/2/2007	Woodbi	.ne,	MD
Baltimore, Maryland	permit. Pages 1 Department of H Important: If Ite any Injury or ot once.		21. Signature of Funeral Service Licensee		22	Name and Addre HAIGHT F Sykesvil	ss of Facility UNERAL 1e, MD	HOME & CH 21784 (41	APEL PA 0)-795-1	(Bo	ox 195)
			23a. Part1. Enter the disease, or complications that ca shock, or heart failure. List only one cause of ea	used the death	n. Do not ent	ter the mode of dyi	ng, such as car	diac or respiratory a	rrest,		Approximate Interval Between Onset and Death
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	res that signed to be deta	ξ.	Part II. Other significant conditions contributing to de	ath but not resu	ulting in the u	nderlying cause giv	ven in Part I.				he cause of death?
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ita		Be Cc	25. Was case referred to medical				26. Place of	1  Yes  Death (Check only o		□Yes	2 No
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Ö	tal or is after al Dire	Certification:	4 ☐ Homicide determined buildir	ig, etc. (Specifi	γ)			City or Tou	vn, State)		
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	To the To the compl	Me	29b. Signature and title of certifier			29c. Licens	se number		29d. Date signed	(Month,	Day, Year)
			/ Wt V V			000	51924		June ?	29,	2007
	(6)		30. Name and address of person who completed cads:	E MM.	9731	Mouches	te Rd	Manche	stor w	107	(10)
	Sta Registi		31. Date filed (Month, Day, Year) 32. Ri	egistrar's Slona	Span						

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-7	Physici /Medi		1. Decedent's Name (First, Middle, La William	T.	F	Emmar	t.		2. Date of De Month June	path Day 28	Year 2007	3. Time of Death 7:30 P <sup>M</sup>
) .	Examir		4a. Facility Name (If not institution, give 2708 Lime Street	re street and number)			4b. City, Town, c	r Location of De			County of Death	
¥ V	Funeral Director		235-56-2808	Sex 7. Age	(In yrs. last bi		If Under 1 Year Months Days	If Under 24 H		th ly, Year)	1.7 COL	place (State or Foreign intry) Virginia
	aryland	-	Usual Residence of Decedent  10a. State 10b. County		10c. City, Tow							10d. Inside City Limits
	h the Ma	Funeral Director	IND P.G. 60	,	Jan	۷( و	HILLS 101. Zip Code			10g. Cit	izen of What Cou	1 Yes 2 No untry?
	eath wit	eral D	2708 Line	STREET  12. Was Decedent E	Ever in 11 S	20748					) SA- 14. Race - Amer	Scan Indian
9036	should be filed within 72 hours after death with the Maryland Menial Hygiene. Tharked other than "neturel", or items 23a or 28a-f ehow marked other than "neturel", or liems 23a or 28a-f ehow maile ovent, it a Medical Exacid or maile motified at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1 Yes 2 N If Yes, Give Year or Dates:	□N01958-		Was Decedent of Hispanic Origin? (Specify Yes or No t Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2☐ (to Specify:				Black, White	
Maryland 21215-0036	nin 72 h In "netu Medicel	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  Cotlege (1-4or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)						16b. K	b. Kind of Business/Industry		
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ylano	should be and Mental I	To Be	Thomas Reeves E					Opa1	Arnolo		Sumame,	
Mar	C1 60 50 18		19a. Informant's Name/Relationship ( Caroline Adkinson						an, Maryl			p Code)
ore,	Pages 1 and 3 nent of Health int: If item 27 iry or other tri		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐		Date 1y 3,	20c. Lo	Location - City or Town, State					
Baltimore,	permit. Pages Department of Important: If it any njury or once.		4 ☐ Donation 5 ☐ Other (Special 21. Sign type Funer II Service Lice		Resur		ion Ceme Name and Addre	tery 200	77		Linton, L Home,	Maryland Inc.
iii	8858	-	234. Part1. Enter the disease, or com	S MOOS	257						l Clinto	n, MD 20735
黎,	Physician /Medical	,	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each iin	θ.				ac or respiratory a			Interval Between Onset and Death
	Examiner		Sequentially list conditions,				ngwom					Solemi
٠, د	outed ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	i consequence	oi).						
2,09789	ificate be executed g physician and as the burial-transit	edical Exa										
P.O. Box 68	eath certif attending for use as	Physician/Med								23d. Date of deliv	f delivery Day Year	
rds, P	w requires that the de been signed by the should be detached	ğ	Part II. Other significant conditions of the Particular of the Par	erlying cause giv	en in Part I.			acco use contribute to the cause of death?  s 2 \( \text{No} \) 3 \( \text{Probably} \) 4 \( \text{Unknown} \)				
		Completed	autopsy prior to performed? death?							prior to co	opsy findings available ompletion of cause of 2 \( \subseteq \) No	
V I	yaician: Th s certificate director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ X No	Hospital:	nt 2□ER/Oι	itnatient	3□ DOA Oth		eath Check only o		3 ☐Other (Speci	6.1
Division of	Hospital or Attending Physician: 44 hours atter death. Funeral Director: After this certificately filled in by the funeral director,	ation: T	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day)	y 28b.	Time of Injury	28c. Injun Wor	y at	28d. Describe			197)
DIV	Ital or Attendi	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (St. City or Town								)	al Route Number,
	To the Hospital of within 24 hours af To the Funeral D completely filled in	Medical	29a. Certifier 1 Check only one) 1 Medical Example 1	ysician: To the best o niner: On the basis of and manner stat	examination an	e, death o	eccurred at the tin stigation, in my o	ne, date and place pinion, death occ	ce, and due to the curred at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)
)	To th withir To th comp	Me	29b. Signature and title of certifier	<del></del>			29c. Licens	e number			e signed (Month, 6/29(0	
	30+1		30. Name and address of person who OSVALOS W-60	completed cause of de	eath (Item 23a)	(Type, Pr	int) LCFWTOA	LOAD LOAD	# 500 CM	me	58162069	mD 20 746
	Sta Registr	100	31. Date filed (Month, Day, Year)	32. Registre	s Signature	K -	Speak i					
DHM	IH 17 Rev 1/20	001	1-1 7002	J - J		1						

DHMH 17 Rev 1/2001

Registrar

State

DHMH 17 Rev 1/2001

Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

MOMOHMD

0 5 2007

31. Date filed (Month, Day, Year)

8700 CENTRAL AV. #301, LANDOVER MD 20785

07-04995 James Fields Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

mes Fields	State of Maryland / Department of Health and Mental Hygiene  1-For State  Certificate of Death  Reg. No. 2007 21											2155				
Physicia		egistrar I. Decedent's Name (First, Midd	e,Last)			2. Date of D Month					Day Year 1922			e of Death		
edical Examin	er	JAMES SAMUEL I		June City, Town, or Location of Death				2007	County of Deat		22 1115					
	4	4a. Facility Name (if not institution 235 West South Street	[4	b. City, Tov Frederic		ocation of L	Death			rederick	.,					
	4	5. Social Security Number	6. Sex	7. Age (In yrs. I	ast birthday)	If Under		If Under 2	24Hrs.	8. Date of Bir	th(MM/E	OD/YYYY) g. Bi	rthplace	(State or		
Funeral Director	,		1 X M 2 F		47 Yrs.	Months	Days	Hours	Min.	10/11/	195		Foreign Country) DC			
	-	242 98 0705 Usual Residence of Decedent	1X M Z F		47 113.								1			
E STATE OF THE STA	A 100 M	10a. State 10b. County		10c. City	, Town or Locati	on								nside City Limits		
	EDEDEDICK											1 X Yes 2 No				
daryland 28a-f show d at once.	Director	10e. Street and Number		10f. Zip C				1	0g, Citizen of What Country? UNITED STATES							
th the Maryland 23a or 28a-f sho notified at once.		230 WEST PART			1.0.14		701	ania Origin	2 / \$20	oify Ves or No		14. Race - Ame				
th with cems 2 t be n	Funeral	11. Marital Status  1 X Never Married 2 N	12. Was De Armed F		I.S. 13. Wa	s Decedent es, specify	or Hisp Cuban,	Mexican, F	Puerto R	cify Yes or No ican, etc.)		White, etc.	inodir iiri			
er dea			1 X Yes	2 No par 1 9 7 8 – 1 9	981 1	Yes 2 X	No	specify:				Specify: BLACK				
urs aft tural"	함	15. Decedent's Education (Spe	or Dates:		16a. Deceden	t's Usual O	ccupatio	on (Give ki	nd of wo	rk done	16b. k	Kind of Business	s/Industr	y		
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5-0036 led within 72 hc Hygiene. other than "ni the Medical Ex	Completed	12TH			TRUCK	DRIV		9 Mother's	Name /	First, Middle,		PRIVATE				
Fled v Hygir d other		17. Father's Name (First, Middle					'			. MILL		ourname,				
2121 2121 ould be fi Mental marked ic event,	o Be	THESSALONIA F  19a. Informant's Name/Relation			19b. Mailing	Address	(Street		er or Ru	ıral Route Nu	Number, City or Town, State, Zip Code)					
MD 2 d 2 shou lth and I n 27 is r	ㅣ	THESSALONIA F		ATHER	5300	WHEEI	ER	ROAD				L, MD 20745				
	ı	20a. Method of Disposition			Place of Dispos crematory or ot		e of cem	netery,		Date	20c.	20c. Location - City or Town, State				
nor Pages ent of nt: If		1 X Burial 2 Crematic 4 Donation 5 Other S		MA	RYLAND		ANS	CEM	07/	10/200	7 0	CHELTEN	MAF.	MD		
Baltimore, permit. Pages 1 ar Department of Her Important: If ite	1	21 Sinceture of Funeral Service Licensee 22. Name and Address of Facility AND SHATT STIMERAL HOME OF MARYLAND, INC.											INC.			
E F P B	Thysician 23a. Port I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or her										), MD 20	<u>J/45</u>	proximate Interval			
Physician /Medical		23a. Part I. Enter the disease, of allure. List only one caus	e on each line.				uying,	3001, 00 00					Ве	etween Onset and Death		
.xaminer		Immediate Cause (Final diseas or condition resulting in death)		sive Cardiov		ase							+			
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	ner	if any, leading to immediate cause. Enter Underlying Cause	t	a consequence	of):			• :								
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Box 68760, e death certificate be the attending physical for use as the bured for use as the	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in	Ale a	s, outcome of pre		etal death	3	Ectopic	pregnar	ncy	23	3d. Date of delive Month	Day	Year		
K 68	iciar	past 12 months?	4 Pre	gnant at time of		ther (Spec	ify)				- 1					
BO) e death the att	hysi			known			201100.0	aluon in Da	et I	23e Dio	tobacco	o use contribute	to the c	ause of death?		
P.O. B es that the d igned by the	by P	Part II. Other significant cond	ditions contributing	g to death but no	t resulting in the	underlying	cause g	giveninia				No 3 <b>✓</b> F				
ords, P.O. w requires that as been signed be should be deta	ted l								-	24a. Wa		24b. Were	autops	y findings available		
aw red aw red nas be 2 shou	ple									per	opsy formed?	? death	1?	letion of cause of		
tal Rec ian: The l certificate l ector, page	Completed						76 Place	e of Death	(Check (	1 Yes	2	No 1 🗸	res	2 100		
/ital Rec	Be	25, Was case referred to medi examiner?	Hospital:	Inpatient 2	ER/Outpatie		OA	Other <sub>4</sub>		g Home 5	Resid	dence 6 🗸 O	ther: Sce	ene		
of Vid Physic ter this	<u>P</u>	1 Yes 2 No	28a. Da	ate of Injury	28b. Time o		28c. Inju	ıry at Work	ς?	28d. Describ	e how it	njury occurred				
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The control of the									Route Number, City							
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Di To the Hospital within 24 hours To the Funeral	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)											use(s)				
To th within To th	Medical		and manne	er stated.				se number				d. Date signed				
	Σ	23D. Signature and the or cer	1 / 1 1	11/)			O.C.	.M.E.			Ju	ıly 1, 2007				
<b>—</b>		30. Name and address of pers	son who completed of	cause of death (II	tem 23a)											
1		Laron Locke MD.	Assistant Med			n Street	, Balti	more, M	1D 212	201						
	100	31. Date filed (Month, Day, Ye	ar) 32	. egistrar's Sigr	nature	- 100										

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Louis Franklin, Jr. Leonard 10:55 AM 30 2007 June /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Clinton Southern Maryland Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Dec 12, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Washington DC 53 261 88 5762 Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits show ir than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 1 Yes 2 No Maryland Prince George Upper Marlboro Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20772 14317 Govenor Lee Place United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2√√No If Yes, GiveXX Year or Dates: 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: þ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 721 (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bluecross & Blueshield Systems Analyst permit. Pages 1 and 2 should be filed i Department of Health and Mental Hygic Important: If item 27 is marked other i any Injury or other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Betty A. Thompson Leonard L. Franklin, Sr. ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8904 Columbine Lane, Upper Marlboro, MD 20772 Betty Ann Franklin (Mother) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Clinton, MD 4 □ Donation 5 ☐ Other (Specify) Lee Crematory July 3: 2007 21. Signature of Fur ral Serve Licensee 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d the Har Alexandria Ferry Road, Clinton, MD 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final AORTIC ANEUIYER UPTURED **Physician** ABDOMINAL resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if ary, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Box 68760, Ce. attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) signed by the a 2 □ No Division or Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 21 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 2 No To the Hospital or Attending Physician: within 24 hours a er death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 ☐ Yes 1 Xinpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? 28a. Date of Injury 28d. Describe how injury occurred Certification: (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 🔣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Duan A. Drakes, M.D. 8100 Goodluck Road Suite 401, Lanham, MD 20706 JUL 0 5 32 Registrar's Signature 31. Date filed (Month, Day, State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death July 1, <sup>Day</sup> 2007 **Physician** Flaherty Grace 10:00 A<sub>M</sub> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Summerville Assistant Living Bowie 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye. May 28, ] 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1□M 2□ Yrs Director 1929 Pennsylvania 578 36 8950 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f shorthe Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Maryland | Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14997 Health Center Drive #238 20716 United States Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ∐Yes 2√ No If Yes, Giv**a** X Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No 3 XWidowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary Federal Government permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 Is marked other any Injury or other traumatic event, I 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frances Maloney Harvey Bratton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7904 Rosaryville Road, Upper Marlboro, MD 20772 Kathe Crosariol (Niece) 20a. Mathod of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) July 7, Date 2007 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Clinton, MD Cemeterv Resurrection 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old 21. Signature of Funeral Service License M01284 Alexandria Ferry Road, Clinton, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiral ry arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** al has /Medical (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, been signed by the attending physician should be detached for use as the buris Completed by Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 □Ectopic pregnancy Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9∏Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown Was a., autopsy performed? Ves 22 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has certificate 1∐ Yes after death.

Director: After this certification by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 🏖 No Hospital: Other: ٩ 1 🔲 Inpatient 2 ☐ ER/Outpatient 3□ DOA Wursing Home 5 Residence 6 □Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 12Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aff To the Funeral D completely filled in 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Raid Dakheel, M.D. 4000 Mitchellville Road Suite 216, Bowie, MD 20716

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

ORIGINAL

DHMH 17 Bev 1/2001

Gaskins Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 08:20 M 29 2007 June Gaskins Freddie Lee /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore
| Flinder | Year | If Under 24 Hrs. | Sinai Hospital Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) **Funeral** Days Months Hours 1□ M 2√□ F Director 72 218-30-6029 03 GA Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a, State 10b. County A Shours by many land matural, or items 23a or 28a-f show the marked other than "natural", or items 23a or 28a-f show marked other than "natural", or items be notified at most be notified at minimals. x □Yes 2□No Director MD NA Baltimore 10e. Street and Number 10g. Citizen of What Country? 5430 Park Heights Ave Apt 2

11. Marital Status

1 □ Never Married 2 □ Married
3 ★ Widowed 4 □ Divorced

1 □ Yes, Give Year or Dates: 213 21215 U.S.A. 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 No Specify: Black 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Towson State Elementary/Secondary (0-12) College (1-4or 5+) Food Service's University 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ould be f Mental I Freddie Douglas Bowles Minnie Jones ပ es 1 and 2 shound Health and Mitter 27 Is mar 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9602 Watts Road, Owings Mills, Md 21117 Janet A. Dunkley-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any Injury or ot
once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State King Memorial Park 7/5/07 4 ☐ Ronation 5 ☐ Other (Specify) Randallstown, Md 21. Signature of Funeral Service License 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part Enter th. c sease, or complications that ca ---- the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart future. List only one cause on each line. Approximate Interval Between rente myocardial Immediate Cause (Final interetion no wrs Physician disease or condition resulting in death) /Medical Due to (or as a cons uence of): month Examiner disease artery Coronary Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner cardio vasentar disease months · Atherosclerotic burial-transit Due to (or as a consequence of): physician Physician/Medical as attending | IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) ed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Hypertension Hyper lipidemia 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings avallable prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has b lirector, page 2 s autopsy performed? Yes No 1□ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home Thesidence 6 Other (Specify)
Injury at 28d. Describe how injury occurred Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? Certification: 1 Natural
2 Accident (Month, Day Year) Injury 5 Pending investigation 1 □ Yes 2 □ No 24 hours after death Funeral Director: filled in by the 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only within 24 h To the Fu one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0053928 07/02/07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SURAIYA BELUM, MD 2434 W, BELVEDERE AVE, BALTIMORE, MD - 2 31. Date filed (Month, Day, Year) 3 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Reg. No.

State of Maryland / Department of Health and Mental Hygiene Amend Item 26 per verb., 8869,07705/07dhb,
Reg. No.

DHMH 17 Rev 1/2001

			1 - State Amend 4a, PI, PII,	State of MaperMD, g869,	aryland / Dep 7/5/07 TT <sub>Ce</sub>	artment o	of Health	and Me	ental Hyg	giene	7 21561		
			Decedent's Name (First, Middle, Last)						2. Date of Dea		3. Time of Death		
ř.	Physici	_	Kacinda E	C	futberle	1			Day 28	Year			
	/Medic		4a. Facility Name (If not institution, give s		wn, or Location	n of Death		38 07 4:15 AM  4c. County of Death					
	Examin	ier	20.11							Ker			
*			5. Social Security Number 6. Sex		lyers Road e (In yrs. last birthday)	Ches If Under 1		er 24 Hrs.	B. Date of Birth				
	Funeral Director			M 2□F	92 Yrs.	Months D	ays Hours	s Min.	(Month, Day Apr. 11	(, Year)	9. Birthplace (State or Foreign Country) New York		
	4°		Usual Residence of Decedent		74				Арт. Т	1915	New TOTK		
	yland		10a. State 10b. County		10c. City, Town or L	ocation					10d. Inside City Limits		
	Mar Fed st	to	Maryland Kent		Chester	town					1 ☐ Yes 2 No		
	r 284	Directo	10e. Street and Number			10f. Zip Co	ode			10g. Citizen of W	/hat Country?		
	h wit		201 Myers Road			21	620			U.S	.A.		
	deat	Funeral	11. Marital Status	12. Was Decedent Amed Forces?	Ever in U.S. 13.	Was Deceden	t of Hispanic (	Origin? (Spec	ify Yes or No-	14. Race	- American Indian,		
9	or Ite		1 Never Married 2 Married	1 ATYAS 2 TI	Vo.	1 Yes 2			ican, etc.)	4.0	k, White, etc.		
21215-0036	72 hours after death with the Maryland natural', or Items 23s or 28s-f show Jical Examiner must be motified at	d b	3 AWidowed 4 □ Divorced	If Yes, Give Year or Dates:	V.W.11	ILITES AL	I NO Specii	ry:		Specify:	White		
5-0	72	Completed	15. Decedent's Educ (Specify only highest grade		(Give	dent's Usual C	done durina m	ost of working	9	16b. Kind of Bus			
21	within ene. then "	npi	Elementary/Secondary (0-12)	College (1-4or 5	(i/e.	DO NOT use I	etired)			Mechani			
	77 Tan by 1988	S	12	1	Pro	oject M					ting Company		
nd	a ta b ≥	Be	17. Father's Name (First, Middle, Last)		0 1				(First, Middle,	Maiden Sumame			
Maryland	should to and Ment marked umatic	2		ouis	Gutber		Mai	- <i>J</i>			empsey		
lar	C 6 2 2		19a. Informant's Name/Relationship (Type							r, City or Town, S			
	an Balt T 2		Christopher D. Par	sley (Gra									
ore	of to		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ R	emoval from State	20b. Place of Dispe cemetery, cre	osition (Name matory or othe	of r place)	Da	ite	20c. Location - (	City or Town, State		
Ē	Pag nent ant:		4 □Donation 5 □Other (Specify)	omeral nom otato	Baltimore	Nat.	Cem	07/03	/07	Baltimo	re, Maryland		
Baltimore,	permit. Pag Department Importent: I eny injury o once.		21. Signature of Funeral Service License	90		2. Name and A			omol II.				
<u> </u>	#9 # 9		ALTIM	line	32	O4 Mou	ntain	Road Pa	eral no asadena	MaryI	ånd 21122		
			23a. Party. Enter the disease, or compli shock, or heart failure. List only or	cations that caused e cause on each lin	I the death. Do not en	ter the mode o	f dying, such a	as cardiac or	respiratory arr	rest,	Approximate Interval Between		
	Physician		Immediate Cause (Final disease or condition resulting in death)  a. Malignant Melanoma with refastasis 40 icom										
	/Medical		resulting in death)	Due to (or as	a consequence of):	ran	arres	will	1.000	us ones	10 agricus		
	Examiner		Sequentially list conditions										
	p \d/=	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		a consequence of):								
	nd nd trans	Examine	that initiated events										
ó	e exe ien a urial-i	E	resulting in death) Last	Due to (or as	a consequence of):								
8760	law requires that the death certificate be executed as been signed by the attending physicien and a should be detached for use as the burial-transit.	dical								7			
9	n certifica anding pl use as t	Physician/Med	IF FEMALE:										
Box	eath ce attendi for use	an/h	23b. Was decedent pregnant	3c. If yes, outcome		⊒Ectopic pregr	ancy				of delivery		
	death ne atte ed for	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at 9□Unknown		Other (special				Mon	ith Day Year		
P.0	that the de	hy	9 Unknown										
	es the	by F	Part II. Other significant conditions con	tributing to death b	ut not resulting in the u	inderlying caus	e given in Par	rt I.			ibute to the cause of death?		
pro	w require been signature		( copp & 11	3112	3) Ca 9	preson	le lin	th_	1 🗆 Y	es 2 Ho	3 Probably 4 □Unknown		
Division of Vital Records,	awre is be	Completed	Obstanctive Ur	opally	D Hyp	Town	<del>ert</del>		24a. Was a	an 24b. W	Vere autopsy findings available rior to completion of cause of		
ď	0 - 0	E							autop: perfor	med? _ de	eath?		
ta	ician: Th certificate rector, pag	0	25. Was case referred to medical				26. Pla	ce of Death	Check only or				
>		To B	examiner? 1 Yes 2 No	ospital:	ent 2 ER/Outpatie	nt 3 DOA	Othor			ence 6 Othe	er (Specify)		
0	g Physical chis		27. Manner of Death	28a. Date of Inju- (Month, Day			Injury at Work?			ow injury occurre			
<u>o</u>	Attending Phir death. ector: After the by the funeral	atio	1 Matural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da)	y Yea <i>r)</i> Injury	М	1 Yes 2	□No					
Vis	of the death efter death I Director:	1110	3 Suicide 6 Could not be determined	28e. Place of Inju	ury - At home, farm, st	reet, factory, of	fice	28	If. Location (S City or Tow	treet and Numbe	er or Rural Route Number,		
Ö	s efte	Certification:	4 - Homicoo	building, etc	c. (Specify)				City of Tow.	n, State)			
	To the Hospital or At within 24 hours effer of To the Funeral Direct completely filled in by	dical (	29a. Certifier 1 ertifying Physical Check only 2 Medical Examin	ician: To the best	ut iny kinowledge deat	h occumad at t	he time, data	and place an	d dus to the e	raties(e) and mar	mar se stated		
	he H in 24 he F plete	0	one)	and manner sta	rexamination and/or in	vestigation, in	my opinion, a	eath occurred	rat the time, c	ate and place, a	nd due to the cause(s)		
	To the within 2 To the complet	Σ	29b. Signature and title of certifier			29c. L	cense numbe	ır	2	29d. Date signed	(Month, Day, Year)		
•			1/1/Cller,	MD.			)2/3	13	a.	6/28/	107		
	26.	1	30. Name and address of person who co	mpleted cause of d	eath (Item 23a) (Type,	Print)				1	,		
6	2 1		KIN K. WUN,	415 10	ashington !	fue., C	hesto	town	me	2162	0 ~		
W.	Sta		29b. Signature and title of certifier    III ( Culcum )  30. Name and address of person who co    III	32 Registra	ar's Signature								
1	Registr	ar	JUL 0 5 200	STEPHEN STAN	J. BO	all							

			1 = For State Registrar	State of Maryland	•		f Health a of Death	nd Mental H	ygiene Reg. No.	007	21562
			1. Decedent's Name (First, Middle, Last	)				2. Date of E Month	eath Day	Year	3. Time of Death
	Physici /Medio		Richard Ea	rl Gordon				June	30, 2		10:51 A <sup>M</sup>
	Examir		4a. Facility Name (If not institution, give				m, or Location of			County of Death	
			15700 McKendree				andywin			ince Ge	
	Funeral Director		3,, 00 022,	7. Age (In yrs. lasi	Yrs.	If Under 1 You Months Da	ear If Under 2 ays Hours		Day, Year)	9. Birth Coul	place (State or Foreign ntry)
	pu *		Usual Residence of Decedent  10a. State 10b. County	10c. City, 7	own or Lo	cation					10d. Inside City Limits
	sho	ō	Maruland -	24 1		. 1 1					1 ☐ Yes 2 ☐ No
	28a-1	ect	Maryland St. Marys	Mecr	ianics	sville 10f. Zip Co	de		10g. Citiz	en of What Cou	ntry?
	with po a	Funeral Director	29674 Jennifer	Drive		206				United	Ctatas
	ne 23	era	11. Marital Status	12. Was Decedent Ever in U.S.	13. \			in? (Specify Yes or Puerto Rican, etc.)		4. Race - Ameri	can Indian,
<b>.</b>	ther d	F	1 ☐ Never Married 2 Married	Armed Forces? 1X Yes 2 No WWI]	1			Puerto Rican, etc.)		Black, White,	
ဗ္ဗ	urs a	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 □ Yes 24 □	No Specify:			Specify: Wh	ite
21215-0036	within 72 hours after deeth with the Maryland ene. then "natural", or iteme 23e or 28e-f show he Madical Exemples inval be inclified at	Completed by	15. Decedent's Edu (Specify only highest grad		16a. Deced	ient's Usual O	ccupation one during most	of working	16b. Kin	nd of Business/In	ndustry
7	thin ?	npie	Elementary/Secondary (0-12)	College (1-4or 5+)			one during most etired)	,		ъ.	
7	ygien yerth t, th	So	12		Auto	Mechar	- 1	's Name (First, Midd		o Repai	r
B	tal H d oth	Be	17. Father's Name (First, Middle, Last)	C 1						Sumame)	
3	J Mer narke	၉	Richard Lee  19a. Informant's Name/Relationship (T)	Gordon	10b Mailie	a Addross /St		Anna Hart ror Rural Route Num		Town State Zi	n Code)
Maryland	d 2 sh th and 7 is n traun		Gerald Richard Go					ve, Mechar			
<b>6</b>	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural; or iteme 23e or 28e-f show amy injury or other traumatic event, the Madical Experiment must be institled at once.		20a, Method of Disposition					y 5, Dat 2007		cation - City or T	
Baltimore,	ages nt of t: If it	١.,	tXXBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify,	removal from State					Cho1	tophom	Maryland
Ħ	artme artme orteni injury	1 3	21. Signature of Funeral Service License				ns Ceme	Lee Funera			
Ba	Depa impo eny i		Mario X. As	nd monas 7				y Road, Cl			
	-		23a. Part1. Enter the disease, or comp	lications that caused the death.							Approximate Interval Between
	Pnysician		shock, or heart failure. List only of finmediate Cause (Final	a. Atherosel	PAG	Tie (	a artis	acculan	Hea	I Die	Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or as a consequer			, 20 000				
н	Examiner			b							
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequer	nce of):						
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,092	ate be executed hysicien and the burial-transit	E	resulting in death) Last	Due to (or as a consequer	nce of):						
876	ate b hysic the bi	lical	•	d							
x 68	death certificat e ettending phy id for use as th	Mec	IF FEMALE:	23c. If yes, outcome of pregnance	٠,					12d Data of dala	
Вох	ath co	lan/	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal de	eath 3	Ectopic pregr			2	3d. Date of deliving Month	Day Year
o.	0 0 0	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at time of deat 9 Unknown	ii 3[	J Other (specii	у/				
<u>α</u>	The law requires that the death site has been signed by the etter bage 2 should be detached for	H.	Part II. Other significant conditions co	ntributing to death but not resulti	ng in the u	nderlying caus	e given in Part I.	23e. Di	d tobacco u	se contribute to	the cause of death?
ds,	uires sign ld be	d by						1(	∐Yes 2[	□No 3□Pro	bably 4. Onknown
50	w requir been si should	lete						24a. W		24b. Were aut	opsy findings available
Be	The lay	ompleted						ре	topsy rformed?	prior to death?	ompletion of cause of
Vital Records,		ပိ	25. Was case referred to medical				26. Place	of Death (Check onl		10,163	2010
<u>=</u>	S 0 0	OB	examina? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ EF	VOutpatier	nt 3□ DOA	Other: 4 Nu	rsing Home 5 ☐ Re	sidence 6	S COther (Spec	Friends
ا م		Ë	27. Manner of Death	28a. Date of Injury (Month, Day Year)	8b. Time o	f 28c.	Injury at Work?	28d. Describ			
<u>.</u>	Attending r death. ector: After by the fune	atio	1 Natural 5 Pending 2 Accident investigation		,,	М	1 ☐ Yes 2 ☐ I				
Division	r Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, str	eet, factory, of	ffice		(Street and Town, State)		ral Route Number,
	ital o irs aff rai Di lled ir										
	To the Hoepital or Attentwithin 24 hours after deati To the Funeral Director: completely filled in by the	edicai	(Check only 2 Medical Exam	iner: On the basis of examination and manner stated.	adga daat n and/or in	h conumed at t vestigation, in	he time, date an my opinion, dea	th occurred at the time	ne cause(s) e, date and	and manner as place, and due	stated. to the cause(s)
	thin 2 the mplei	Med	29b. Signature and title of certifier	and manner stated.		29c. L	icense number		29d. Dat	e signed (Month	, Day, Year)
	James Parity Co.		1201	About on			21004	1927	T,	11, 3	200
			30. Name and address of person who d	ompleted cause of death (Item 2	3a) (Type	Print)	Y-0)(		20	1	2
	2		SALVADON SI	vsTer 3001	Hos	tal	Dire	Chever	g,	hay	ad
	Sta		31. Date filed (Month, Day, Year)	32. a gistrar's Signatur	re	0			1		
	Regist	rar	JUL 0 5 2	007 Broken B		Per le					-

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** OMEWARD 30 2007 SUL /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner ALTIMORE UNIVERSITY of MARKAND MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs, last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Months Days 732 09 9656 Usual Residence of Decedent 1 □ M 2 😿 F 08.11. Director Irinidad Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show Examiner must be notified at 1 Yes 2 □ No Baltimore Director MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5910 Frankford 23a Trinidad Funeral Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give/ Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Specify: Black 'natural', or 1 ☐ Yes 2 📉 No Baltimore, Maryland 21215-0036 Specify: ģ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Owner FIRECETY Store Department of Health and Mental Hygis Important; If item 27 is marked other any injury or other traumatic event, the once. 18. Mother's Name (First, Middle, Maiden Surnarde) 17. Father's Name (First, Middle, Last) Be Veronica <u> Lleiscn</u> Derrich 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1 Daughter Frankford Avenue Baltimere MD Marva Simon 21206 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Matura Village Cemetery 07:11 200+ Trinidad
22. Name and Address of Facility Vaugha C. Creene Juneary Service 21. Signature of Funeral Service Licensee 23a. Part1. Enter de disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. iberty Ind Thandaulstein MD 21133 Immediate Cause (Final disease or condition resulting in death) 1ETASTATIC Physician PANCREATIC CANCER /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dise to for as a consecuence of Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the at d be detached fo 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completéd 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 2 No 2 No certificate 1□ Yes 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1. Inpatient 2 ER/Outpatient 3 DOA Certification: To this within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral ( 1 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and ade

31. Date filed (Month, Day,

Year)

0 5

South

who dompleted cause of death (Item 23a) (Type, Print)

Registrar's Signature

1050

Using

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BAUTIMORE,

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 6:11 PM JUNE Hoback 29 2007 Nancy Clara /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** St. Marv's Leonardtown St. Mary's Hospital 8. Date of Birth (Month, Day Year) Sept. 8,1923 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 M 2 F Virginia 83 Director 226-28-1257 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If Item 27 is marked other than "natural" or items 200 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 ☐ No Director Maryland | St. Mary's Mechanicsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20659 U.S.A. 27030 Millseat Drive Funeral 14 Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 9 3 ☐Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 9th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Spoon Anna Albert Rich 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25535 Hignutt Road Denton, Maryland 21629 Nancy D. Blazejak (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date washington National Cemetery 1 Burial 2 □ Cremation 3 □ Removal from State Sutiland, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Lee Funeral Home, Inc. 21. Signature of Funeral Service License 6633 Old Alexandria Ferry Road Clinton, MD 20735 2001 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) iac **Physician** minuth /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopo, performed r Vas 200 No autopsy 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 3□ DOA Certification: To 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director; After this certificate has been signed by the attending physician and Division or Vital Records, P.O. Box 68760

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Medical

State Registrar

DHMH 17 Rev 1/2001

egistrar's Signature

and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) O. Box 524, Leonardton, MD, 2065C 31. Date filed (Month, Day,

Year)

0 5

29a. Certifier

(Check only one)

29b. Signature and title of certific

07-04959 Anne Harrison

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

unic	riamson		1-For State Control of Position Control of Pos		. No. 201	2   55							
	Physici	an/	Registrar  1. Decedent's Name (First, Middle,Last)	2. Date of Death		3. Time of Death 1023 hrs							
Wed ~	ical Exami		ANNE FENTON HARRISON  4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of I	June 29, 20	4c. County of Dea								
			3515 St. Paul Street Baltimore		11								
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 2 18 - 0 4 - 8 5 9 4 1 M 2 F 4 1 Yrs. Months Days Hours	(MM/DD/YYYY) 9. B /1965									
-	any	. [	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits							
	<b>*</b> *	_	MD BALTIMORE			1 Yes 2 No							
	faryland 28a-f show I at once	Director	10e. Street and Number 10f. Zip Code	g. Citizen of What Co	untry?								
	ith the Maryland 23a or 28a-f sho notified at once	٥	308 NORTHFIELD PLACE 21210	308 NORTHFIELD PLACE 21210 USA									
	ath wit items?	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin 14. Married Forces? 15. Was Decedent of Hispanic Origin 16. Married Forces? 17. Was Decedent of Hispanic Origin 18. Was Decedent of Hispanic Origin 19. Married Forces? 19. Was Decedent of Hispanic Origin 19. Married Forces? 19. Married Forces? 19. Married Forces?		14. Race - Ame White, etc.	erican Indian, Black,							
	fter de l', or		3 Widowed 4 Divorced If Yes 2 No 1 Yes 2 No specify:		Specify: W	WHITE							
	hours a natura Examir	ed by	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kindering most of working life. DO NOT usual Occupation)		16b. Kind of Busines:	s/Industry							
	36 nin 72 1 s. than "q dical I	plet	Elementary/Secondary (0-12) College (1-4 or 5+)  5+ HIGH SCHOOL COUN	ISELOR	COUNSEL	OR							
	21215-0036  uld be filed within 72 hours after deatl Mental Hygiene. marked other than "natural", or ite cevent, the Medical Examiner must	Completed	17. Father's Name (First, Middle, Last) 18.Mother's	Name (First, Middle, M	aiden Surname)								
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	hou hou is n	J.	19a. Informant's Name/Relationship (Type, Print )										
	ore, MC s 1 and 2 s of Health an If item 27		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City	or Town, State							
	Baltimore, permit Pages I ar Department of Her Important: If ite injury or other tr		4 Donation 5 Other Specify: ST. DAVIDS-NICHE	7/03/07		CITY, MD.							
	Baltimo permit Pag Department Important: injury or ot		21. Signature of Funeral Service Licensee  22. Name and Address of Facility HENRY W. JENK 16924 YORK RE	NS CO. ,MD. 211	11.								
	Physician Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as car failure. List only one cause on each line.	rdiac or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and Death							
-	vaminer	î	Immediate Cause (Final disease or condition resulting in death)  a. Multiple Injuries  Due to (or as a consequence of):										
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		iner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause										
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	cox 68760, cath certificate be executed attending physician and for use as the burial - transit	Medical	UNPENDED AMENDED			. ].							
	760, ficate be g physical the buri	/Me	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic	pregnancy	23d. Date of deliv	ery Day Year							
	Division of Vital Records, P.O. Box 687 tal or Attending Physician: The law requires that the death certificate that death.  an Director. After this certificate has been signed by the attending pled in by the funeral director, page 2 should be detached for use as the	sician/	past 12 months?  4 Pregnant at time of death 5 Other (Specify)	programoy									
	Bo he deal y the at	Phys	1 Yes 2 No 9 Unknown 9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part	t 1 23e. Did to	bacco use contribute	to the cause of death?							
	P.O. s. that I gened be e detac	δ	Tarin Other Signment Conditions Company to Court Section 100 for the C			robably 4 Unknown							
	rds, require been si hould b	Completed		24a. Was a		autopsy findings available o completion of cause of							
	eco he law ate has age 2 s	dwo		perfor	med? death	?							
	al R ian: T certifica ctor, p	BeC	25. Was case referred to medical examiner?										
	f Vit Physic or this c	To	examiner? 1  Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other4  27. Manner of Death		Residence 6 V Ot	ner: Scene							
	nding th r: Afte	jon:	1 Natural 5 Pending Jun 29, 2007 1023 hrs 1 Yes 2	Subject pred	ipitated from he	ight							
	r Atter dea irector	ficat	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc			Rural Route Number, City							
	Div pital o ours af ceral D	Certification:	4 Homicide determined (Specify) Other (parking garage)	or Town, S 3515 St. Paul	Street, Baltimore,	MD							
	Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physicist completely filled in by the funeral director, page 2 should be detached for use as the burit	Medical (	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occ	ce, and due to the causeurred at the time, date a	e(s) and manner as s and place, and due to	tated. the cause(s)							
	To To COM	Mec	and manner stated.  29b. Signature and title of certifier  29c. License number		29d. Date signed (I	Month, Day, Year)							
			O.C.M.E.		June 30, 2007								
	10		30. Name and address of person who completed cause of death (Item 23a)  Jack Titus MD: Deputy Chief Medical Examiner 111 Penn Street, Baltimore, N	/ID 21201									
	S	tate											
	Regis	trar	JUL 0 3 2001 Bloker to Bosseles										

		Registrar				Cer	rtifica	te of i	Death			Reg. No.	<u>ZUU</u>		21500	
Physic	cian	1. Decedent's Name (First, Mic								2.	Date of D	Day	/ Year	r	3. Time of Death	
/Mec		Rosalind									une	27,	2007		6:00 P M	
Exam		4a. Facility Name (If not institut Sun Rise As		4b. City, Town, or Location of Death  Pikesville					4c. County of Death <b>Baltimore</b>							
Funera	1	5. Social Security Number	6. Sex		(In yrs. last	birthday)	If Unde	er 1 Year Days	If Under 24 H		Date of Bi (Month, D	rth	9. B	irthplace	e (State or Foreign	
Directo	r	213-28-7639	1 □ M 2 □ X	F	76	Yrs.	Months	Days			r 06				land	
and		Usual Residence of Decedent  10a. State 10b. Cour	ntv		10c. City, T	own or Lo	cation							10d	Inside City Limits	
if e, INIAL FIGURE A LAIS-0050  S 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene.  Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Funeral Director	Maryland Bal	Ltimore			esvil									1 ☐ Yes 2 📉 No	
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ter de item	ű	11. Marital Status 1 ☐ Never Married 2 ☐ M	Arme	Decedent Eved Forces? Yes 2 XX No		13. \	was Dec If Yes, sp	ecify Cuba	lispanic Origin? an, Mexican, Pu	(Specify erto Ric	y Yes or Na an, etc.)	D-	<ol> <li>Race - An Black, Wh</li> </ol>			
UUSO nours aff ural", or	by F	3 Widowed 4 □ Divorce	If Yes	s, Give or Dates:	,	1	1 ☐ Yes	2 <b>](</b> ] No	Specify:				Specify: W	hite	<b>e</b>	
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aryları aryları and Mental I s marked ol	2	William Lee	Boyd						Dorot	hy E	lizal	eth	Arno1d			
2 shc and ls ma		19a. Informant's Name/Relatio	nship (Type. Print)	)		19b. Mailin	ng Addres	s (Street	and Number or	Rural R	oute Numi	per, City o	r Town, State	, Zip Co	ode)	
and and lealth m 27		Robert L. Jon	es	(9	Son) 3	39 Mi	ller	s Rui	n, Mill:	sbor	o, De	lawa	re 19	966		
ges 1 and 2 it of Health If item 27		20a. Method of Disposition  1 XBurial 2 Cremation	n 3 🗆 Removal f	rom State	20b. Place ceme					Date			cation - City of		,	
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ysici is ce direc	10 B	examiner? 1 Yes 2 No	Hospital:	1 🔲 Inpatient	2 ER/	/Outpatien	t 3 🗆 🗅	OA Othe					6 Sther (Sc	ecify A	Kristed Ling	
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S Regis	tate trar	29b. Signature and title of certies  30. Name and address of person  Remains SC  31. Date filed (Month, Day, Yea  JUL 0	5 2007	Registrar	s Signature	Local	were	,							144	

DHMH 17 Rev 1/2001

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Registrar

31. Date filed (Month, Day, Year)

Division or Vital Records, P.O. Box 68760,

ZUBAIR SHAIKH, GOOD SAMARITAN HOSPITAL, 5601 LOCH RAVEN BLVD, BALTIMORE-MD 21239

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** D James Edward Haney TUNE 27 2007 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Baltimore Washington Medical Center Glen Burnie If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days 1X M 2□ F March 12, 1946 Pennsylvania 61 Director 216-50-3204 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or Items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Anne Arundel Maryland Severn 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21144 Completed by Funeral 1404 Norcross Lane 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1♥ Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 21 No Specify Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates White er than "natur the Medical E 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) University of Maryland Project Manager If Item 27 Is marked other or other traumatic event, ti 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental Dorothy Boyer F. Joseph Haney ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Severn, Maryland 21144 Charlotte R. Haney/wife 1404 Norcross Lane 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition N Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) MD Veterans Cemetery 7/3/2007 Crownsville, Maryland 22. Name and Address of Facility Donaldson Funeral Home & Crematory, 21. Sign pre of Funeral Service Licensee Thomas ianita 1411 Annapolis Road Odenton, Maryland 21113 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final month Physician MYELODYSPLASTZE disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Willebronds Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed and Due to (or as a consequence of): physician Physician/Medical as attending properties for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 Fetal death 3 □Ectopic pregnancy Month in the past 12 months? 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9□Unknown 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 No 1 ☐ Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s has autopsy certificate 2 director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 1 ☐ Yes 1 Inpatient P After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: Hospital or Attending 1 XNatural 2 ☐ Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours a ter dea To the Funeral Director filled n by the 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 60796 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

IN.

Baltimore, Maryland 21215-00

Records, P.O. Box 68760,

Division or Vital

State

31. Date filed (Month, Day, Year)

#305

305 HOSPITAL DRIVE, GLEN BURNE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** HUDGINS 2159 PM UIL 01 200 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number Examiner EMORIAL HOSPITAL 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 2 2 9 - 18 - 9793 Usual Residence of Decedent 1 ■ M 2 X F Director with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show Department of Health and Mental Hygiene. Important: or Items 23a or 28a-f shov Important: If Item 27 is marked other than "natural"; or Items 23a or 28a-f shov any Injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director BALTIMORE MARYLAND 10g. Citizen of What Country? 10e. Street and Number 4233 HICKORY Pages 1 and 2 should be filed within 72 hours after death Funeral Race - American Indian Black, White, etc. . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE ģ 3 Midowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) EXTILE WORKER MANUFACTURING 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State. Zip Code) #233 HICKORY AVE APTB BALTIMORE MD 21211
e of Disposition (Name of Date 20c. Location - City or Town, State KIETH R, HUDGINS
20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) OAK LAWNCEMETERY JULY 6, 2007 BALTIMORE, MD. 22. Name and Address of Eachity ER, INC. FUNERAL HOMES
1901 EASTERN AVE. BALTIMORE, MD. 21231 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or espiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician; The law requires that the death certificate be executed Due (or as a consequence of): Division or Vital Records, P.O. Box 68760 the attending physician Physician/Medical IF FEMALE: If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by No 3 Probably 4 Unknown 1 TYes 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an this certificate 1☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one Medical Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes DOA 1 ☐ Inpatient 2 ☐ ER/Outpatient 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Injury at Work? After Natural 5 ☐ Pending investigation Injury To the Hospital or Attendlr within 24 hours after death. To the Funeral Director: A 1 □ Yes 2 □ No 2 ☐ Accident filled in by the 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and tipe of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person

*Ĵ* State

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day,

**ORIGINAL** 

32. Registrar's Signature

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 29 2007 **Physician** JUNE 11:15 & /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 3206 ELLIOTT STREET BALTIMORE N/A Date of Birth (Month, Day, Year)
DEC. 25,1939 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months 219-26-9397 MARYLAND Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 28a-f show must be notified at 1 X Yes 2 □ No Director BALTIMORE MD N/A 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō 3206 ELLIOTT STREET 21224 U.S.A. items 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 □ No If Yes, Give Year or Dates: 1961-65 14. Race - American Indian, 11. Marital Status Black, White, etc. Wever Married 2 ☐ Married Specify: WHITE Baltimore, Maryland 21215-0036 ö 1 ☐ Yes 2 No þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4or 5+) MACHINIST WESTERN ELECTRIC 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) LEONARD J. HALAJ MARGARET AMRHEIN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any Injury or other trau once. ELIZABETH C. KITKO/ SISTER 3206 ELLIOTT STREET, BALTIMORE, MD. 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State SACRED HEART OF JESUS 7/3/07 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses TTLLY & ZEILER INC. FUNERAL HOME CONKLING STREET, BALTO., MD. 21224 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) nemona **Physician** W /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as sonse) Examine or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 No 1☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Medical Certification: Injury 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 1

Division or Vital Records, P.O. Box 68760.

Registrar DHMH 17 Rev 1/2001

State

(Check only one)

29b. Signature and title of certifier

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31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

22. Registrar's Signature

🗡 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death SHIRLEY **ESTELLE** JOHNSON **Physician** 2007 July 9:35 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Baltimore Genesis Healthcare-Hammonds Lane If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 □ M 2 K F 220-18-4292 81 Mar 22, 1926 Director Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Eximiner must be notifiled at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Maryland N/A Baltimore 1¥ Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21230 USA 2039 Deering Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Yes 21 No Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Be Completed by Specify 3 Midowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Housewife & Mother Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Emma Elizabeth Bachman Henry Ludon Wroten မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Daughter) 114 Allgate Rd., Owings Mills, Md. Diane L. Norris 20b. Place of Disposition (Name of cemetery, crematory or other place Glen Haven Mem Pk Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 7/6/07 Glen Burnie, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Fusial Service Licensee Kevin E Ecker P.A. 21230 McCallydPolymak Funeral Home, P 130 East Fort Ave., Balto., Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ?mort /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending the security of the second control burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Be Completed by Physician/Medical the IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐ No Month Day Year 4 □ Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Jonknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ Ho 24a. Was an 1□ Yes 2 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To hours after death. Ineral Director: After this y filled in by the funeral di 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Injury investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier

State Registrar

Medical

29b. Signature and title of cert

30. Name and address of person

Year)

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31. Date filed (Month, Day,

29c. License number

29d. Date signed (Month, Day, Year)

and manner stated

who completed cause of death (Item 23a) (Type, Print)

901 32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last, **Physician** 2007 /Medical 4b. City, Town, or Location of Death Bolti More County of Death Facility Name (If not institution, give street and number) Examiner f Under 1 Year If Und Birthplace (State or Foreign Country) 8. Date of Birth (Month, Da Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours 1 M 2 □ F 107-40-6753 Usual Residence of Decedent Tenns vania Director 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Exa<u>miner must be notified at</u> 1 Yes 2 No Be Completed by Funeral Director 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number tountain 21015 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?
1 □ Yes 2 □ No 11. Marital Status 1 Never Married 2 Married white 1 ☐ Yes 2 No Maryland 21215-0036 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. PONOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, ဂ္ 19b. Mailing Address (Street and Number or Rural Route Numb 19a. Informant's Name/Relationship (Type. Print) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 Removal from State 300 Kosedale 10 4 Donation 5 Dother (Specify) DI, MISTHILAD 21. Signature of Funeral Service Licenses Services-BelAir se, or complications that cause, the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. List only be cause on fact line. Approximate Interval Between Onset and Death art1. Enter the dise shock, or heart failu Immediate Cause (Final disease or condition resulting in death) PANCREATIC CANCER **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Completed by Physician/Medical the attending plant of the last as IF FEMALE f yes, outcome pf pregnancy I□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 3 TEctopic pregnancy Month Year in the past 12 months? 5 Other (specify) 4□Pregnant at time of death 1 ☐ Yes 2 ☐ No ed by the detached 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No After this certificate Hospital or Attending Physician: 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 1 Yes 2 No 4 ☐ Nursing Home 5 ☐ Residence 6X1Other (Specify) HOSPICE 1 Inpatient 2 ER/Outpatient 3□ DOA P 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: Injury 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident filled in by the 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 | Medical Examiner: On the basis of examination and/ar investigation in the property of the 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifi

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State Registrar DR. TARIQ MAHMOOD 2300 DULA

1. Date filed (Month, Day, Year) 32. Pigistrar's

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2300 DULANEY VALLEY RD.

32. projectrar's Signature

TIMONIUM, MD 21093

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) June 30 2007 2007 9:30 A. M Young Dai Kim 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Baltimore County 8 Melanie Court Baltimore 8. Date of Birth (Month, Day, Year) Aug • 28 • 1949 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Seoul, Korea Days 1 🖾 M 2 🗆 F 57 092-74-1728 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2/□No Maryland Baltimore County Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21234 United States 8 Melanie Court 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Korean 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Grocery Store Manager Grocery Store 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ki Pyo Kim Dae Soon Lee 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baltimore, Maryland 21234 Mrs. Grace Donghe Kim(wife) 8 Melanie Court 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Timonium, Maryland Dulaney Valley Mem. July 03,2007 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Peaceful Alternatives Funeral & Cremation Ctr., P. A 2325 York Road Timonium, Maryland 21093 21. Signature Approximate Interval Between Onset and Death ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each line. ate Cause ( Gastini

Physician /Medical **Examiner** 

Physician

/Medical

**Examiner** 

Director

Funeral

Completed by

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**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi After this certificate has been signed by the funeral director, page 2 should be detached within 24 hours after death

To the Funeral Director:
completely filled in by the t

Division or Vital Records, P.O. Box 68760,

- 1	disease of condition	a					
	resulting in death)	Due to (or as a consequent	ce of):				
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury that initiated events	bDue to (or as a consequence	ce of):				
	resulting in death) Last	Due to (or as a consequence	ce of):				
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal de. 4 ☐ Pregnant at time of death 9 ☐ Unknown	ath 3 □Ectopic preg			23d. Date of delive	ery Day Year
Completed by Pr	Part II. Other significant conditions of	contributing to death but not resulting	g in the underlying cau	se given in Part I.		24b. Were auto	pably 4 Unknown
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o Be	examiner? 1 ☐ Yes 2 █ No	Hospital: 1 Inpatient 2 ER/	'Outpatient 3 DOA	Othor		6 □Other (Specia	(y)
ation:	27. Manner of Peath 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) n	b. Time of 28d Injury M	l Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	jury occurred	
Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		, farm, street, factory, o	office	28f. Location (Street City or Town, St		al Route Number,
Medical (	29a. Certifier 1 DertifyIng Pr (Check only one) 2 Medical Exam	hysician: To the best of my knowler miner: On the basis of examination and manner stated.	dge, death occurred at and/or investigation, in	the time, date and place, n my opinion, death occur	and due to the cause red at the time, date	e(s) and manner as s and place, and due t	stated. to the cause(s)
Ĭ	29b. Signature and title of certifier		29c. I	icense number	29d. l	Date signed (Month,	Day, Year)

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State

Registrar

31. Date filed (Month, Day,

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32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

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	Physicia /Medic		1. Decedent's Name (First, Middle, Last)  StepNamie  K	inlesey	1		2	Date of Deal Month		3. Time of Death
	Examin		4a. Fecility Name (If Not institution, give street and number) Good Saman fan Hosp	rital	4b. City, Town, Balt	or Location		4	4c. County	of Death which City
	Funeral Director		189-14-9515 1□M 2XF	(In yrs. last birthda 86 Yrs	Months Davs		24 Hrs. 8 Min.	Date of Birth (Month, Day)	Year)	Birthplace (State or Foreign Country)     PENNSYLVANTA
	yland now		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or	Location	·				10d. Inside City Limits
	Ba-fsh	Director	MD BALTIMORE	TOW	SON					1 Tyes 2 No
	with th		10e. Street and Number		10f. Zip Code			1	0g. Citizen of W	hat Country?
	ns 23	erai	1521 COTTAGE LANE  11. Marital Status 12. Was Decedent E	ver in U.S. 1	212 3. Was Decedent of If Yes, specify Cu		igin? (Specif	fy Yes or No-	USA 14. Race	- American Indian,
036	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If item 27 is marked other than "natural; or items 23s or 28s-f show or other traumatic event, the Medical Engine Francische rolliffed at or other traumatic event, the Medical Engine Francische rolliffed at	by Funeral	1 Never Married 2 Married 1 Never Married 2 Married 1 Yes, Sur 3 Widowed 4 Divorced  Amed Forces? 1 Yes, Sur Year or Dates:		If Yes, specify Cu			can, etc.)	Specify:	k, White, etc. WHITE
5-0	"natur	etec	15. Decedent's Education (Specify only highest grade completed)	(G	cedent's Usual Occu	e during mos	st of working		16b. Kind of Bu	siness/Industry
21215-0036	d within giene.	Completed	Elementary/Secondary (0-12) College (1-4or 5+12TH GRADE	.)	e. DO NOT use retir HOMEMAKER				OWN I	HOME
Maryland	be filed ntal Hygi ed other event, I	Be	17. Father's Name (First, Middle, Last)						Maiden Sumame	a)
aryli	should be and Mental marked o	2	ANDREW BUCZEK  19a. Informant's Name/Relationship (Type, Print)	19b. Ma	ailing Address (Stree		VAVAIL er or Rural F		; City or Town, S	State, Zip Code)
	and 2 saith a n 27 is er tras		SYDNEY B. KIRKSEY/SON	12	36 CALDWE	LL COU	ET -	N FEL	CAMP, MI	21017 City or Town, State
Baltimore,	T P P P		20a. Method of Disposition  1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  ' 4 ☐ Donation 5 ☐ Other (Specify)	cemetery, c	sposition (Name of crematory or other pl D MEM. PA	1	7/10/		20c. Location - 0	
Balti	permit. Pa Departmen Important: any injury once.		21. Signature of Funeral Service Licensee	-	22. Name and Add	ress of Facili	ty THE J BLVD		N FUNERA	AL HOME, P.A. 21286
			23a. Part1. Enter the disease, or complications that caused t shock, or heart failure. List only one cause on each line	he death. Do not						Approximate Interval Between
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8760,	icate be executed physician and s the burial-transit	dical	d							
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S, D	The law requires that the site has been signed by the bage 2 should be detached.	d by Ph	Part II. Other significant conditions contributing to death but Diabetes	not resulting in the	e underlying cause g	jiven in Part I				ibute to the cause of death?
Division of Vital Record	he law rec le has bee age 2 shou	Completed by	Stroke					24a. Was a autops perform	ned? d	Vere autopsy findings available rior to completion of cause of eath?  Yes 2 No
ital	etor, p	Be C	25. Was case referred to medical examiner?			26. Place	e of Death (	1 □ Yes : Check only on		165 2210
of V	Phyaician: r this certific ral director,	P	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatien		Herit 3 DOA				ence 6 Othe	
no	Attending Is death. ector: After by the funer	ation	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation  28a. Date of Injury (Month, Day)	Year) 280. Time	y W	uryat ork? ⊒Yes 2. □		a. Describe no	ow injury occurre	90
Divis	ol or Attendi safter death. I Director: A d in by the fu	Certification:	2 □ Suiside 6 □ Could not be	y - At home, farm, (Specify)	street, factory, office	Э	28	f. Location (St City or Town	reet and Numbe n, State)	er or Rural Route Number,
	To the Hospitel or Attending Physicien: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical C	29a. Certifier (Check only one)  Certifying Physician: To the best of and manner state	examination and/or	eath occurred at the r investigation, in my	time, date an opinion, dea	nd place, and ath occurred	d due to the ca at the time, d	ause(s) and mar ate and place, a	nner as stated. nd due to the cause(s)
	To the within 2 To the complet	M	29b. Signature and title of certifier		29c. Licer	nse number				(Month, Day, Year)
				A.D.	D6	043	5		June	30 2007
	12		30. Name and address of person who completed cause of de WINLERED V ACAR 5601 Loc			1timor	e, MD	21239	9	
	Sta Registr	1	31. Date filed (Month, Day, Year)  JUL 0 5 2007	's Signature	aske					

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			For State Registrar	State	of Maryla	•	rtment o			and M	ental Hygi	ene	07	21575
			Decedent's Name (First, Middle	, Last)					-		2. Date of Death	Day	Year	3. Time of Death
	Physicia /Medic		Russell	Ellswort		Cagle					July 1	, 2007		1:10PMM
	Examin		4a. Fecility Name (If not institution Fort Washi				4b. City, Tow Fort					4c. County		rae's
			5. Social Security Number	6. Sex		s. last birthday)	If Under 1 Ye		If Under		8 Date of Birth			
	Funeral Director		212665277	1 ☐ M 2 ☐ F	50	Yrs.		iys	Hours	Min.	8. Date of Birth Month, Day, Oct. 15	.1956	Wash	lace (State or Foreign try) ington, DC
	D D		Usual Residence of Decedent											
	anylan show	_	10a. State 10b. County		10c. C	City, Town or Lo							1	0d. Inside City Limits 1 ☐ Yes 2 4 No
	Ba-1	ecto	Maryland Char	les		Waldo					10	g. Citizen of V	Mhat Cour	
	a or 2	ā	10e. Street and Number 2725 Pinewood	Drive			10f. Zip Coo	601			10	_	U.S.A	
	ne 23	era	11. Marital Status	12. Was Dec	edent Ever in	U.S.   13. V			panic Ori	gin? (Spe	ecify Yes or No- Rican, etc.)	14. Race	e - Americ	an Indian,
9	after or ite	Fur	1 ☐ Never Married 2 ☐ Marr	Amed F ied 1 Tes If Yes, G	2 No		rYes, specity 0 I□Yes 2□		, mexican Specify:	i, Puerto	Hican, etc.)	Specify	k, White,	
21215-0036	within 72 hours after death with the Maryland ene. Then "naturel", or items 23a or 28a-f ehow ha Medical Examinar must be notitled at	Completed by Funeral Director	3 ☐ Widowed 4 ☐ Divorced	Year or I	Dates:									White
2	"nati	lete	15. Deceden (Specify only higher	s Education t grade completed	)	16a. Deced	lent's Usual Oi kind of work di DO NOT use re	ccupati one du stired)	ion <i>ring mo</i> si	t of worki	ng 1	6b. Kind of Bu	ısıness/in	dustry
7	iene.	mo	Elementary/Secondary (0-12) 12th	College	(1-4or 5+)		anic	,				PEPCO	Powe	er Co.
פ	e filec al Hyg othe vent,	Bec	17. Father's Name (First, Middle,				-	1			(First, Middle, M	_		
Maryland	Menta Menta arked	To	Hooper Rus	sell K	agle					orot			own	
Jar	2 shot and rism	à i	19a. Informant's Name/Relations		,						il Route Number,			
e,	1 and Heelth em 27 ther t		Diane Skidmore 20a. Method of Disposition	e (Daught					-		aldorf.	Mary Lai Oc. Location -		
nor	ages int of t: if it		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		State	Place of Dispo cemetery, cren		place)	)	July 2007	3,		524545	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene.  Depertment must be notified at Andrew.		21. Signature of Funeral Service			Lee Cres	: Name and A	ddress	of Facilit		e Funera	Clinto 1 Home		
ñ	Depermine of mines		Kienta D.	Sills	MOIZ	0.1				110			•	, MD 20735
	Physician be executed /Medical Examiner sthe pural-transit	cal Examiner	23a. Part 1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	each-line.	equence of):		_			- C. 20 A			Approximate Interval Between Onset and Death
P.O. Box 687	Attending Physicien: The law requires that the death certificate crosable.  scotor: After this certificate hes been signed by the attending phys by the funeral director, pege 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live 4 ☐ Preg 9 ☐ Unk		etal death 3 [ f death 5 [	]Ectopic pregn ] Other (s <i>pecif</i>	y)				Мо		Day Year
	w requires the been signed should be de	۵	Part II. Other significant condition	ons contributing to	death but not re	esulting in the u	nderlying caus	e giver	n in Part I			/		ne cause of death?
Vital Records,	sicien: The law re certificete hes bee rector, pege 2 sho	Completed									24a. Was an autopsy perform	ed?	prior to co death?	psy findings available mpletion of cause of 2 No
Vita	icien Sertifi ector	Be	25. Was case referred to medica examiner?	Hospital:				Other		of Death	(Check only one	)		
	ding Physicien: h. After this certific funeral director.	٠ <u>.</u>	1 Yes 2 No 27. Manner of Death	1		ER/Outpatier 28b. Time of			4 🗀 190		me 5 Resider 28d. Describe hor			ý)
O	th. : Afte	tlon	1 □ Matural 5 □ Pendir 2 □ Accident investi		of Injury nth, Day Year)	Injury	м	Injury a Work?	? es 2 ☐			. ,		
Division of	i Çite	Certification;	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ined 286. Plac	e of Injury - At ding, etc. (Spe	home, farm, str	eet, factory, of	fice			28f. Location (Str City or Town		er or Rur	al Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical Ce	29a. Certifier (Check only onle) Certifyin 2 Medical	ng Physician: To the Examiner: On the and ma	ne best of my k basis of exami nner stated.	nowledge, deatl	n occurred at the occurred at	ne time my opi	e, date an inion, dea	nd place, ith occuri	and due to the ca red at the time, da	use(s) and ma ite and place,	anner as s and due t	tated. the cause(s)
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	3		30. Name and address of person	V. 18	Ar J.	17 70 // 17 // 10	Print)	J	ijs to	n /	Zet F.	+ wa	86	°7 Nd 2074
	Sta Registr		31. Date filed (Month, Day, Year)	5 2007 32.	Bigistrar's Sig	nature	rede	,						*

		For State Registrar	ate of Maryland / Do	epartment of He Certificate of D	eaith and iv Death		g. No.	U /	
Physicia	an .	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day	Year 2007	3. Time of Death
/Medic	al -	Margaret A. Kuhn		th Ch. Taura and	anation of Dooth	July		y of Death	1,204
Examine	er	ta. Facility Name (If not institution, give street Keswick Multi Care		4b. City, Town, or L Baltimo	ore		n/a		
Funeral Director		5. Social Security Number 6. Sex 1 □ M 2	X F 105	day) If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, July 17	Year) 1901	9. Birthp Coun Oh	
ehow od at		Usual Residence of Decedent   10a. State   10b. County	10c. City, Town Baltim					1	0d. Inside City Limi
28a-1	Director	10e. Street and Number		10f. Zip Code		10	g. Citizen of	What Cour	itry?
23a or		700 W. 40th St.		212	11		USA		
ital Hygiene. Id other than "natural", or items 23a or 28a-f show event, the Maulcal Examinar must be mutified at	Funeral	Ar 11X Never Married 2 ☐ Married 1 [	as Decedent Ever in U.S. med Forces? Yes 2 1 No	13. Was Decedent of His If Yes, specify Cuban	panic Origin? (Sp , Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		ce - Americ ack, White,	
atural', c	ted by	3 Widowed 4 Divorced Ye  15. Decedent's Education		1 ☐ Yes 2 ☐ No  Decedent's Usual Occupat Give kind of work done du	tion		6b. Kind of		
Hygiene. other than "n ent, the Med	Completed		ollege (1-4or 5+)	one kind of work doine do life. DO NOT use retired) porate Cashi			harma	ceutic	al Mfg.
al Hyg	BeC	17. Father's Name (First, Middle, Last)				e (First, Middle, M e Liebon		me)	
Mental arked o	2	Louis Kuhn		1				- O	0-4-1
7 le m traum		19a. Informant's Name/Relationship (Type, Pi	, i	Mailing Address (Street ar					
nt of Health and Mental  If Item 27 le marked or or other traumatic eve	1	Denise Bliss/niece  20a. Method of Disposition  1X Burial 2 □ Cremation 3 □ Remov	20b. Place of I cemetery	026 Valley M Disposition (Name of c, crematory or other place	7/5/	Date 2	Oc. Location	- City or To	wn, State
Department Important: I eny injury o once.	1	4 □ Donation 5 □ Other (Specify)  21 Signature of Supplier Service Licensee.	Dulaney	y Valley Mem		rdens T	imoni	ım, MIL	
Impo eny ir	1	Lewell I Lemmon  23a. Part 1. Enter the disease, or complication		Lemmon Fune 10 W. Padon	ral Home			111ey,	Inc.
Me was been signed by the attending physicien and signed by the attending physicien and sage 2 should be detached for use as the burial-transit	dical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d	Due to (or as a consequence of Due to (or a conseque	f):	esvasci	lar du	sease		Onset and Death
by the attending p	Physician/Mec	in the past 12 months?	yes, outcome of pregnancy □Live birth 2 □ Fetal death □Pregnant at time of death □Unknown	3 ☐Ectopic pregnancy 5 ☐ Other (specify)				ate of deliver	ery Day Year
pe de	þ	Part II. Other significant conditions contribut	ing to death but not resulting in	the underlying cause give	n in Part I.	23e. Did tob			he cause of death
cete has been si , page 2 should t	Completed					24a. Was ar autops perform 1 Yes 2	/	prior to co death?	psy findings avail mpletion of cause
certificete rector, pag	Be C	25. Was case referred to medical			26. Place of Pea	th (Check only one			
After this uneral di	၉	examiner?  1	a. Date of Injury 28b. Ti	ime of 28c. Injury jury Work	at ?	ome 5 ☐ Reside 28d. Describe ho		- ' '	(y)
ifter deat Director: in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28	e. Place of Injury - At home, far building, etc. (Specify)		∕es 2 □No	28f. Location (Street and Number or Rural Route N City or Town, State)		al Route Number,	
within 24 hours after of To the Funeral Direct completely filled in by	edicai Ce	(Check only 2 Medical Examiner: (	n: To the best of my knowledge, On the basis of examination and and manner stated.						
within 24 hours after To the Funeral Dir completely filled in	Me	29b. Signature and title of certifier  Thabelle Vac	Gregor 17)	29c. License	number		od. Date sign		
			1 1				1		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 05 **Physician** VIOLA LEE 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4. County of Death Examiner PRINCE GEORGES DOCTOR'S COMMUNITY HOSPITAL LANHAM If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Months Days Hours 1□M **%**X Director 577 30 6788 82 NOV. 10, 1924 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at XXYes 2 □ No Directo CAPITOL HEIGHTS MD PRINCE GEORGES 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö 505 SUFFOLK AVENUE 20743 UNITED STATES items 23a Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. ☐ Yes **XX** No I Yes, Give XX Never Married 2 Married ŏ 1 ☐ Yes XX No Specify. Specify: BLACK þ 3 Widowed 4 Divorced Year or Dates: "natural" Completed event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) if Health and Mental Hygiene. 12TH FOOD SERVICE WORKER PRIVATE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MARY JOHNSON ပ္ ROGER LEE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9603 JULIETTE DRIVE CLINTON, MD 20735 MICHAEL DAVIS / NEPHEW 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any Injury or ot once. XXBurial 2 ☐ Cremation 3 ☐ Removal from State HARMONY MEMORIAL PARK 07/07/2007 LANDOVER, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Name and Address of Facility
MARSHALL S FUNERAL HOME OF MARYLAND, INC. 4308 SUITLAND ROAD SUITLAND, MD 20746 Approximate Interval Between Onset and Death Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, for heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consa uence of) **Examiner** Sequentially list conditions, if any loading to infractal cause. Enter Underlying Cause (Disease or injury that initiated exerts) Due to for as a consequence of Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): the burial-Division or Vital Records, P.O. Box 68760 physician Physician/Medical as IF FEMALE: If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes XX No Month Day Year 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 □Unknown 1 □ Yes cate has been si , page 2 should I Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performe 1 🗆 Yes 1⊟ Yes 2/5 or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 🏖 No Inpatient ဥ 2 ER/Outpatient 3 DOA this 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Injury 1 Natural (Month, Day Year) 5 ☐ Pending within 24 hours after useum.

To the Funeral Director: After the funeral Director of the funeral investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital Medical Examiner: On the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

3

State Registrar

31 Date filed (Month, Day, 2007

0 5

29b. Signature and title of certifiq

32 Registrar's Signature

ho completed cause of death (Item 23a) (Type, Print)

(Center Dr. tre, Greenhelt, M) 20730 Greenway

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** July 2007 10:00a M Minnie Alice Anderson Livesay 3 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore City 920 Arion Park Road 8. Date of Birth (Month, Day, June 7 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🔀 F 95 218-18-4230 VA June 1912 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County and 2 should be filed within 72 hours after death with the Marylar nath and Mental Hygiene atth and Mental Hygiene 1. 27 is marked other than "natural", or items 23a or 28a-f show nor traumatic event, the Medical Examiner must be notified at the reaumatic event, the Medical Examiner must be notified at 1 ∏Yes 2 □ No MD Baltimore City Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 920 Arion Park Road 21229 Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 20 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black White etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔯 No Baltimore, Maryland 21215-0036 Specify: Specify: white þ 3 ☐Widowed 4 ☐ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) homemaker domestic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charlie Anderson Nora Jones 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 ment of Health a ant: If item 27 Is 5701 West Falls Rd., Mt. Airy, MD 21771 Inez White (daughter) Department of Health Important: If item 27 any Injury or other troonee. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Crest Lawn Memorial Marriottsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licenses Dauge Staight Sterbert P.O. Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-trar Due to (or as a consequence of) physician Physician/Medical the as asn 23c. If ves, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year for in the past 12 months? 1☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed Be Certification: To

the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, within 24 hours after death To the Funeral Director: completely filled in by the

		CR	1-			1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ☐ Known		
						24a. Was an autopsy performed?  1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No		
5. Was çase refer	red to medical				26. Place of De	ath Check onl_one		
examiner? 1 Tes 2	No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐			Other: 4 Nursing	me 5 Aesidence 6 Other (Specify)		
7. Manner of Deat 1 Natural 2 ☐ Accident	h 5	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	M 2	8c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred		
3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined	28e. Place of injury - At he building, etc. (Special	ome, farm, street	, factory	r, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one)						ce, and due to the cause(s) and manner as stated. curred at the time, date and place, and due to the cause(s)		

29d. Date signed (Month, Day, Year)

Registrar

Medical

31. Date filed (Month, Day, Year) State

29b. Signature and title of certifier

0 5

100 MD 32 Registrar's Signature

and address of person who completed cause of death (Item 23a) (Type, Print)

levide Rd. Cetarsnille,

36

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 30<sup>Day</sup> JUNE 2007 ROBERT E LEVINSON 3:35 Рм /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE BALTIMORE 3209 SZOLD DRIVE Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. **Funeral** Months Days Hours 1 M 2 □ F 09/24/1914 MD 92 263-18-5520 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐Yes 2 No **Funeral Director** MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21208 U.S.A. 3209 SZOLD DRIVE 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 □ No If Tes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No WHITE Be Completed by Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) OWNER REAL ESTATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) **KEMPER** ည LEVINSON EMMA 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25 STONEHENGE CIRCLE #3 - BALTIMORE, MD 21208 SAMUEL RUDDIE / FRIEND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HEBREW YOUNG MENS 07/03/2007 WOODLAWN, MD 21. Signature of Funeral Service Licens 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 **Physician** /Medical Be Completed by Physician/Medical Examiner Certification: To

**Examiner** spital or Attending Physician: The law requires that the death certificate be executed rours after death.

neral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or re shock, or heart failure. List only one cause on each line.	spiratory arrest, Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death)  a. Consustable West Faulus	Uniset and Death
Completed by Physician/Medical Examiner	Due to (or as a consequence of):  Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C. Chama — underlying  C. Due to (or as a consequence of):	
ıysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown  3 □ Ectopic pregnancy 5 □ Other (specify) □ □ Unknown	23d. Date of delivery Month Day Year
ed by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1  Yes 2 No 3 Probably 4 Unknown
Complet		24a. Was an autopsy performed? 1 ☐ Yes 2 No
Be	25. Was case referred to medical examiner? 26. Place of Death Co	heck onlone
၉	Hospital:	5 Residence 6 □Other (Specify)
ation:	1 Matural 5 ☐ Pending (Month, Day Year) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No	Describe how injury occurred
ertific	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f.	Location (Street and Number or Rural Route Number, City or Town, State)
Medical Certification:	29a. Certifier (Check only one)  1/2/Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a and manner stated.	due to the cause(s) and manner as stated. at the time, date and place, and due to the cause(s)
Me	29b. Signature and title of seed iffier \\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	29d. Date signed (Month, Day, Year)
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Tuge Rd #300 2150
te ar	31. Date filed (Month, Day, Year)  31. Date filed (Month, Day, Year)  31. Date filed (Month, Day, Year)	

State Registra

within 24 hours a To the Funeral C

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 06 **Physician** ANNYE ARTHUR MC 2007 05:05 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Upper Chesapeake Med Center Bel Air Harford 5. Social Security Number 243-64-3109 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 08-04-1941 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Days Hours 1 □ M 2 ▼ F 65 North Carolina Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. NC Franklin 1X Yes 2 □ No Franklinton Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 970 Gordon Moore Road 27525 IISA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married XXMarried 1 ☐ Yes 🔏 No Specify. Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Gov't Correctional Officer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lottie Bell Perry Murray ED 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Daughter Angela Jarvis 121 Broadneck Crossing, Edgewood, MD 21040 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hawkins Chapel Caretery Creedwar, North Carolina 07/06/2007 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service 814Upshurst NW WISH OR 20011 BIANCHI 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Septic Shock **Physician** disease or conditior resulting in death) /Medical Due to (or as a consequence of) 10 hrs Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): the attending physician Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day 4□Pregnant at time of death 5 Other (specify) ☐Yes 2 ☐No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed Septic armitis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Diabetes meuitus 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has performe 2 2 No filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To 27. Manner of Death 28a. Cate of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death.

To the Funeral Director: After 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of eqrtifier 29d. Date signed (Month, Day, Year) 1063420 June 27, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) pook Dr. Bel Air, MD 21014

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death <sup>Day</sup> 2007 **Physician** 2 4:15a ™ Murphy Trma Elizabeth /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 2621 E. Biddle Street Baltimore 9. Birthplace (State or Foreign Country) VA If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7: Age (In yrs. last birthday) **Funeral** Days Hours Min 1931 1 ☐ M 2 😿 F Yrs. 218-26-7273 75 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location r 28a-f show notified at 10a. State Baltimore 1 X Yes 2 □ No MD N/A Director death with the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ms 23a or USA 21213 2621 E. Biddle Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 7 is marked other than "natural", or items traumatic event, the Medical Examiner m. Was Decedent Ever in U.S Armed Forces? 11 Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☑ No if Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify. Black 3 ☐ Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Church Home Hospital Dietary llth 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) un and Mental H Bookar Herma Smith Cundiff D. ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2621 E. Biddle Street Baltimore, MD 21213 19a. Informant's Name/Relationship (Type. Print) of Health a Wanda Johnson-daughter other t 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If Iter any Injury or oth 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD 7/6/2007 Greenmount Crematory Baltimore 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F.H. East Baltimore, Md. 1101 E. North Ave. 21202 la wane 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) Iterine **Physician** Year /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the same of Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician; The law requires that the death certificate be executed Exami burial-tran Due to (or as a consequence of) P.O. Box 68760, Physician/Medical the as attending p IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year 4☐Pregnant at time of death Day 5 ☐ Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has page 2 autopsy performe 1□ Yes 2 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 2 No 1 ☐ Yes 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 Pending investigation n 24 hours after death.

le Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier within 24 hor To the Fune completely fi (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ď PLACE BALTISMODE 51 PAUL 1)W16151

Registrar

State

31. Date filed (Month, Day, Year)

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1 Decedent's Name (First Middle Last) 3 Time of Death Month July Day **Physician** ROY LESTER MISER 01, 2007 аМ 7:01 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 8205 Washington Blvd., #10 Jessup Howard If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Dec 8 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1□M 2□F Maryland 215-38-4280 64 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show la or 28a-f show t be notified at 1 □Yes 2□No Directo Maryland Howard Jessup 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8205 Washington Blvd., 20794 U.S.A. 'natural", or items 23a 1 and 2 should be filed within 72 hours after death Meatth and Mental Hygiene. em 27 is marked other than "natural", or items 23 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

↑ XYes 2 No 1960 -13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: þ White 3 ☐ Widowed 4 ☐ Typyvorced 1966 Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Grade 12 General Superintendent Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Leta Olga Franklin Roy Elmer Miser traumatic ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
any injury or other trau Cheryl Gilbraith daughter 8205 Washington Blvd., #10 Jessup, Maryland 20794 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State MD Veterans Cemetery 07/05/2007 Crownsville, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee <sup>22</sup> Name and Address of Facility Donaldson Funeral Home, P.A. / M00770 313 Talbott Avenue Laurel, Maryland 23a. Part1. Enter the disease, oncomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List prily one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) End Stage Hepatic Cirrhosis **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 1 Tyes 2 □ No. 9 Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Diabetes Mellitus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Coronary Artery Disease 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? res **2X**No certificate 2X Min 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 X Sesidence 6 Other (Specify) 1 ☐ Yes 2/17/No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? After 1XX Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

Division or Vital Records, P.O. Box 68760, I Director: A after within 24 hours a

To the Funeral I

completely filled

10x

Medical

Dr. Charles Harrison

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

D 41218

July 3, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3900 Loch Raven Blvd.

Baltimore, Maryland

31. Date filed (Month, Di State Registrar

29a. Certifier

(Check only one) 29b. Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death WILLIAM Ε. MAYES SR. Month **Physician** 10.55 PM 2007 UNF /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** GLPN BURNIE AGIMOIZE WASHINGTON ME ALINE ARUNDA ISICAL LENTER 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6 Se Age (In yrs. last birthday) **Funeral** Year 1 X M 2 □ F 75 218-26-0355 Nov. Director 14,1931 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at Director 1 ☐ Yes 2 M No Maryland | Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be r 8204 Forest Glen Drive 21122 U.S.A. **Funeral** 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 MarYes 2 □ No If Yes, Give Year or Dates: 1 □ Never Married 2 Married Specify: White 1 ☐ Yes 2 In No 2 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cable Splicer 11 Bell Atlantic traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Leonard Maves Marv A. Peddicord 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If Item 27 Is any injury or other trai 8204 Forest Glen Drive, Pasadena, Maryland 21122 Ruth A. Maves 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Mem. Park | 07-02-07 Glen Burnie, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Fun ral Service Lice 22. Name and Address of Facility
McCully-Polyniak Funeral Home P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate F. A.

Approximate Approximate Static Part Control of Approximate Interval Between Onset and Death rediate Cause (Final Isease or condition resulting in death) Physician ON GESTIVE /Medical Due to (or as a consequence of) Examiner Cequentiary list conumers, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 modths? 1 ☐ Yes 2 ☐ No Month Vear Day 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 I Inknown 9 ☐ Unknowr Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an page 2 s certificate 2 No 1∐ Yes Hospital or Attending Physician: director, Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 1 Inpatient Certification: To 2 ER/Outpatient 3□ DOA this 27. Man of Death funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After t 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after deatl Funeral Director; the 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) completely and manner stated. within 2 te of certifie 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) 45149 30 Name and address of person who completed cause death (Item 23a) (Type, Print) 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 29<sup>ay</sup> **Physician** 2007 June Robert Paul Mc Nally 2:27P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Owings Mills 8103 A Greenspring Way Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day Hours | Min. | May 3, 1926 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1**∑**M 2□F 484-26-5396 81 Iowa Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10h. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 1 □Yes 2 No MD Baltimore Owings Mills Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8103 A Greenspring Way 21117 Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1∑Yes 2☐No If Yes, Give 4/45 ■ Black, White, etc. 1 ☐ Never Married 2 X Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: White Specify Year or Dates:4/45 ò 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Funeral Director Funeral Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alexander John Mc Nally Ocea Mae Weldon 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rose Marie Mc Nally/Wife 8103A Greenspring Way Owings Mills, MD 21117 Date | 20c. Location - City or Town, Sta | 20c. Location - City or 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Reisterstown, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** mel-s disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter on 3, 1, 5 Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner physician and sthe burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an page 2 performe 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospitał: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manper of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 ☐ Pending investigation 1 🗌 Yes 2 🗌 No within 24 hours after death.

To the Funeral Director: A completely filled in by the fi 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title A Name and address of person who completed cause of death (Item 23a) (Type, Print) Veder AveSvit 22 BelTimore B 2435 Nest BEI edistrar's Signature 31. Date filed (Month, Day, Year) State Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Year Η. McCullough 6:28 P M Clarence June 30 2007 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore St. Joseph Medical Center Towson If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Sept 16, 1927 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Days 79 Months 1 □XM 2 □ F Marviand 212-26-0639 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore Towson 1 □Yes 21 No Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21204 8107 Halton Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 XYes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Engineering Mechanical Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Johnson Margaret Herbert McCullough 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8107 Halton Rd. Towson, Md. 21204 Mrs. P.A. McCullough/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Hilltop Service Co. 7-3-07 Towson, Md. 4 Donation 5 Dother (Specify) 21. Signature of Juneral Service 22. Name and Address of Facility Ruck Towson Funeral Home, 1050 York Rd. Towson, Md. se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, . List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disea shock, or heart failure Immediate Cause (Final disease or condition resulting in death) DILATED CANDIDMY OPATHL 54RS Due to (or as a consequence of): enonmy Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 4 CENTENSION Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? FIBRILLATION 1 🗌 Yes 2XNo 3 Probably 4 Unknown CRESTME 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No ADENOCARCINOMA 24a. Was an autopsy performed? 1 Yes 2 No 26. Place of Death (Check only one)

Physician /Medical Examiner

death certificate be executed

attending physician

been signed by the a should be detached

page 2 should

certificate has

this funeral

After

the

filled in by

To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After

5+1Va

Completed

Be

Certification: To

Medical

Box 68760,

P.O.

Division or Vital Records,

**Physician** 

/Medical

Examiner

Funeral

Director

"natural", or items 23a or 28a-f show edical Examiner must be notified at

filed within 72 hours after Hygiene.

permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natur any Injury or other traumatic event, the Medical

Baltimore, Maryland 21215-0036

Director

Funeral

2

Completed

Be

2

Examiner burial-transit the as for use

Physician/Medical 2

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

25. Was case referred to medical 1 Yes 2 No

1 Natural

3 ☐ Suicide

29a. Certifier

2 Accident

4 Homicide

27. Manner of Death

6 Could not be determined

0 5

5 ☐ Pending investigation

Hospital: 1 ☐ Inpatient

2 ER/Outpatient 3 DOA

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 🗌 Yes 2 🗌 No 28d. Describe how injury occurred

 Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manyler stated. 29b. Signature and title of certifier

29c. License number D0028812 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DIPIETYO 7801 york No SUITE 162 TOWSON, MD ZIZOY 32 Registrar's Signature 31. Date filed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

			For State	State of Maryland				/lental Hyg	iene		
			Registrar		Certifi	icate of L	eath)		eg. No.	0017	21595
П	Physici	an	1. Decedent's Name (First, Middle, Last)	O	C 1-1 10 1	· M.	. i	2. Date of Deat	Day	Year	3. Time of Death
	/Medic		Gabisiella 4a. Facility Name (If not institution, give s		ampo		RaLCS Location of Death		29	County of Death	00:57A"
	Examin	er		lines Hospiz	4/1	3.14	Location of Death	0 1/4	70.	N/A	•
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la		Under 1 Year	If Under 24 Hrs.	8. Date of Birth	14:1	9. Birth	place (State or Foreign
П	Director		N/A 10	M 2 X F / D	Yrs. Mo	onths Days	Hours Min.	(Month, Day,			AL VADOR
400	pu ,		Usual Residence of Decedent	10-00	Taura and anatio				7,		
	arylar show d at	Ä	10a. State 10b. County		Town or Location						10d. Inside City Limits 1 XYes 2 □ No
	he M 28a-f otifie	Director	MARYLAND N/A  10e. Street and Number	13A	TIMO				0.00	(100) -1 (0)	
	a or be n			2.4	]	Of. Zip Code	1 :/	'	G. Citiz	en of What Cou	ADOR
	be filed within 72 hours after death with the Maryland that Hygiene.  3d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral		2. Was Decedent Ever in U.S	6. 13. Was	2/22 Decedent of His	spanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No-		4. Race - Amer	
10	r iter	Fun	1 ☑ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 🗷 No				Rican, etc.)		Black, White	, etc.
2-0036	ours a	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	11/25	Yes 2□No	Specify:	LVADORIA	N	Specify: SALV	ABORIAN
2-0	72 hc 'natu dical	Be Completed	15. Decedent's Educ (Specify only highest grade		16a. Decedent'	of work done d	ation Juring most of worl			d of Business/I	ndustry
2	/ithin ne. han '	Idm	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO N	NOT use retired,	) -			N/n	
N		ပ္ပ	17. Father's Name (First, Middle, Last)	N/A		N/PT	18 Mother's Nam	ne (First, Middle, I	Maiden 9	Surnama)	
and	should be filed nd Mental Hygi marked other matic event, t		4	A 0.6.0							
Maryland		은	19a. Informant's Name/Relationship (Tyr.	<u>M POS</u> ne. Print)	19b. Mailing Ad	ddress (Street a	パイパノケリ and Number or Ru	DELCS /4. ral Route Number			ip Code)
S	nd 2 state at trau		VLADIMIR CAMPO	SIFATHER	_		_				NO 21224
ē,	s 1 and of Healt item 2 other		20a. Method of Disposition	20b. Pl	ace of Disposition	n (Name of	/			ation - City or	
altimore,	Page nent o int: If		1 MBurial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	emoval from State	-		á i	1. 1007	BAL	TIMOR	F M D 2/111
	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service License	е	22. Na	me and Addres	s of Facility	INC. FUN	ERA	LHOME	E MD, 2/111
<u> </u>	o a E c		Catherine M.	Zeiler	196	1 CASTE	TRN AVE	BALTIM	ORE.	MARY	LAND 21231
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the death.	. Do not enter th	e mode of dying	g, such as cardiác	or respiratory arr	est,		Approximate Interval Between
3	Physician		Immediate Cause (Final disease or condition	Acute 1.	WeLoi	idke	ukemi	ia a			Onset and Death
5	/Medical Examiner		resulting in death)	Due to (or as a consequ		\ .					h 116 -
	xaminioi	e	Sequentially list conditions bif any, leading to immediate	Due to (or as a consequ	-USIE	Disco	2se			- 4	2 months
	rted nsit	njn	cause. Enter Underlying Cause (Disease or injury that initiated events	Penal	Faila	11 10				<	of mouth o
Ć,	execun and ial-tra	Examine	resulting in death) Last	Due to (or as a consequ	- p		,				1 14014 (213
38760	ficate be executed physician and is the burial-transit	edical	d	IN TRUCKO	NiaL	Hev	noreho	ige			/week
_	rtifica ng ph as th	Ned	IF FEMALE:					0	-1		
. Box	leath certifi attending   I for use as	an/l	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome pf pregnar 1 □ Live birth 2 □ Fetal		opic pregnancy			2	3d. Date of deli	very Day Year
	at the dea by the at stached fo	Physician/M	1 ☐ Yes 2 🗷 No 9 ☐ Unknown	4□Pregnant at time of de 9□Unknown	ath 5 ☐ Oth	ner (specify)				MONTH	Day rear
P.0	hat thed by detact		Part II. Other significant conditions con	tributing to death but not resul	lting in the under	ving cause give	en in Part I.	23e. Did tol	bacco us	se contribute to	the cause of death?
Vital Records,	The law requires that the death certif the has been signed by the attending age 2 should be detached for use as	d by		•		,,		1 U Y	es 2	Mo 3 □ Pro	obably 4 □Unknown
Ö	w require been sig should t	ete						24a. Was a	D	24h Wara au	topsy findings available
Ř	The lav	Completed						autops perfori	sy med2	prior to c death?	ompletion of cause of
ta			25. Was case referred to medical				26 Place of Dea	th (Check only on	2 <b>X</b> No	1 □ Yes	2 No
	lysici is cer direct	o Be	examiner?	ospital: 1 Npatient 2 ☐ E	ER/Outpatient 3	DOA Othe	er.	ome 5 Reside		□Other (Spec	eify)
0	ding Phys h. After this funeral dir	T:U	27. Manner of Death 15 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at	28d. Describe ho	ow injury	occurred	
SIO	eath. or: A the fu	atic	2 Accident investigation	2-4		M 1 🗆 1	/es 2□No				
Division or	or At fter d Jirect in by	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At hor building, etc. (Specify,	me, farm, street,	factory, office		28f. Location (St City or Town	treet and n, State)	Number or Ru	ral Route Number,
	pital ours a eral [		29a. Certifier 1 Y Certifying Phys	ician: To the best of my know	uledge death on	Curred at the tim	o date and place	and due to the e	auco(c)	and manner as	stated
	e Hos 24 hc Fun etely	Medical	(Check only one) 2 Medical Examin	er: On the basis of examinati and manner stated.	ion and/or investi	igation, in my of	pinion, death occu	rred at the time, d	late and	place, and due	to the cause(s)
	To the Hospital or Attending Physician: within 24 hours after deals.  To the Funeral Director: After this certification in the funeral director, the funeral director, and the funeral director director, and the funeral director dire	Me	29b. Signature and title of certifier	^		29c. License	number	2	9d. Date	signed (Month	n, Day, Year)
	1		> 11/ xw m	M		RES.	- 000		JUN	IE 29	,2007
	1 0		30. Name and address of person who co	mpleted cause of death (Item	23a) (Type, Prin	1)					
	1		MELANIA BEMO	BEAI	4000 1	1. Wor	FE ST	· Bal-	+ M	0212	87
B	Sta Registr		31. Date filed (Month, Day, Year)  JUL 0 5 2007	mpleted cause of death (Item	Acoust.	P					

DHMH 17 Rev 1/2001

			1- State of Maryland / Department Certificate			ene 2007	21507
	Physici	an	1. Decedent's Name (First, Middle, Last)  Dorothy A. O'Connell		2. Date of Death July	1 <sup>Day</sup> 200 <sup>Y</sup> 9 <sup>ar</sup>	3. Time of Death 8:40 p M
	/Medic Examir			own, or Location of Death		4c. County of Death	P
	Funeral Director	ier	7733 Telegraph Road 37–A Se  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1	Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day,	Anne Ari	place (State or Foreign ntry)
4-7	24		Usual Residence of Decedent		Jan. 11,	1933 Penns	sylvania
	anylan show d at	-	10a. State 10b. County 10c. City, Town or Location			1	0d. Inside City Limits 1 ☐ Yes 2 🛣 No
	the M 28a-f notifie	recto	Maryland   Anne Arundel   Severn   10f. Zip C	code.	10	g. Citizen of What Cour	
	3a or	io le	7700 17 1	144		U.S.A.	,
36	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed by Funeral Director	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married  1 Yes 2 No 1 Yes 2	ent of Hispanic Origin? (Sp fy Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: Whi	etc.
5-0036	tural'	q pa	15 Decedent's Education 16a Decedent's Usual	Occupation	1	6b. Kind of Business/Inc	
215	thin 72 e. an "na Medic	nplet	(Specify only highest grade completed) (Give kind of work life. DO NOT use	done during most of work retired)	king		·
12121	should be filed within nd Mental Hygiene. marked other than "	Co	10 N/A Line Wo		e (First. Middle, M	Paperbox Co	ompany
and	d be fi ental F ced ot	o Be	Harry Anthony Minnix	Freda	Vivian	Safford	
Maryland	2 should be filed within and Mental Hygiene. is marked other than aumatic event, the Me	2		Street and Number or Rui			Code)
	and 2 ealth a n 27 is		James L. O'Connell (Son) 4002 Moun	tain Road Pa	asadena.	Marvland 21	1122
Baltimore,			20a. Method of Disposition 1 A Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name cemetery, crematory or off	of ner place)	Date 2	Oc. Location - City or To	own, State
薑	Pa and:		4 Donation 5 Other (Specify) Cedar Hill Cem  21. Signature of Fuperal Service Licensee 22. Name and	etery 07/0	05/07	Brooklyn Pa	ark Maryland
Ba	permit. Departr Importa any inji		McCull 3204 M	y-Polyniak E ountain Road	Tuneral H	ome, P.A.	1 21122
68760,	Physician /Medical Examiner but sician and stree private and stree private street physician and street physician a	cal Examiner	23a. Par Enter the disease, or complications that caused the death. Do not enter the mode six ok, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):	with li	vec m	elesten	Interval Between gnset and Death
.O. Box	attending for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2  O 9 Unknown  23c. If yes, outcome pf pregnancy 1  Live birth 2  Fetal death 3  Ectopic pre			23d. Date of deliver	ery Day Year
rds, P	w requires that the de been signed by the should be detached	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cat	ise given in Part I.	23e. Did toba	acco use contribute to to s 2 No 3 □ Prot	he cause of death?
or Vital Records,	'slcian: The law re s certificate has bever lirector, page 2 sho	Completed			24a. Was an autopsy perform	prior to co	opsy findings available mpletion of cause of
Vita	lcian Sertific ector,	Be	25. Was case referred to medical examiner?		th (Check only one		
on or	ling Phy I. After this funeral d	tion: To	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  27. Manner of Death 1 Vatural 5 Pending (Month, Day Year) 2 Accident investigation Rospital: 1 Inpatient 2 ER/Outpatient 3 DOA  28b. Time of Injury M	Other: 4 Nursing Ho c. Injury at Work? 1 Yes 2 No	ome 5 Resider 28d. Describe how	nce 6 □Other (Specil w injury occurred	(y)
Division	To the Hospital or Attendi within 24 hours after death.  To the Funeral Director: A completely filled in by the fo	Certification:	3 Suicide 4 Homicide  6 Could not be determined  28e. Place of injury - At home, farm, street, factory, building, etc. (Specify)	office	28f. Location (Str. City or Town,	eet and Number or Rura State)	al Route Number,
	To the Hospital within 24 hours a To the Funeral completely filled	Medical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred a Medical Examiner: On the basis of examination and/or investigation, and manner stated.				
	To the within to the comp	Me	29b. Signature and Soft certifier Aftending Physician, 29c.	License number 0 144 9 7 3		July 2 . a	
	H		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  GURMEET S. SAWHNEY MD 325H.	ospital D	rive .	202 Gleni	2007 . Busmie MD
	Sta Registi		31. Date filed (Month, Day, Year)  32. Registrar's Signature				

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

**ORIGINAL** 

32. Registrar's Signature

Here &

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. C. 1. Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** June 29 Pay 2007ear Charles F. Poffel 3:00 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Parkville Baltimore 8409 Nunley Drive Apt.C If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months, Day, Year) Dec. 10, 1924 5. Social Security Number 6. Sex. 1 ☐ M 2 ☐ F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 217-12-6677 82 Maryland Director Usual Residence of Decedent r 28a-f show notified at 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits MD Baltimore Parkville 1 ☐ Yes 2 No Director 10f. Zip Code 21234 10e. Street and Number 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or any Injury or other traumatic event, the Medical Examiner must be I USA 8409 Nunley Drive Apt. C 12. Was Decedent Ever in U.S. Agned Forces? 14 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White etc. White 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify. 2 lf Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Give kind of work done during most of working

Vending Machine Operator Gift Novelty Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) Margurite Schultz 17. Father's Name (First, Middle, Last) To Be Edward A. Poffel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
8409 Nunley Drive Apt.C-Parkville, MD 21234 19a. Informant's Name/Relationship (Type. Print) Catherine Poffel-spouse 20a. Method of Disposition

AD Burial 2 ☐ Cremation 3 ☐ Removal from State 20h Place of Disposition (Name of Date 20c. Location - City or Town, State Garrison Forest 7-5-07 Garrison, Maryland 4 Donation 5 Dother (Specify) VA Cemetery 21. Signature of Funeral Service Licensee 8800 Harford Road Parkville, MD 21234 EVANS FUNERAL CHAPEL tudo AND CREMATION SERVICES 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** PEAQ( KMEWTI /Medical Due to (or as a consequence of): **Examiner** SCUD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transi Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at tirne of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ Vo 3 Probably 4 Unknown peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy performed? 2 No 1□ Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 → No Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 5X Residence 6 □Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier

P.O. Box 68760. Division or Vital Records,

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director, 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0018662 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) -120 Sister Pierre Dr. Suite 207 Towson, mD 9+1 Dr. William Goldiner 2. Registrar's Signature 31. Date filed (Month, Day, Year) State 2007 Registrar **ORIGINAL** 

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Anthony Lamar Porter 1- For State Certificate of Death

	Registrar	Ta pa	Reg. No. tte of Death 3. Time of Death
Physician/ ledical Examiner	1. Decedent's Name (First, Middle,Last)  Anthony Lamar Porter	Mo Jui	onth Day Year 1800 hrs
	4a. Facility Name (if not institution, give street and number)  3 Fernsell Ct. #1D	4b. City, Town, or Location of Death Rosedale	4c. County of Death Baltimore County
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birt	Months Days Hours Min.	Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) Texas
i ow any	Usual Residence of Decedent  10a. State	or Location Rosedale	10d. Inside City Limits 1  Yes 2 No
after death with the Maryland al", or items 23a or 28a-f show iner must be notified at once.	10e. Street and Number 3 Fernsell Court Apt.1D	10f. Zip Code 21237	10g. Citizen of What Country? USA
or items 23a must be noti	11. Marital Status 1 XNever Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No	13. Was Decedent of Hispanic Origin? ( Specify If Yes, specify Cuban, Mexican, Puerto Rican	
s after or uiner n	3 Widowed 4 Divorced if Yes, Give Year or Dates:	1 Yes 2 No specify:	Specify:
2 hour Lexar	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  12  Mai	Decedent's Usual Occupation (Give kind of work d during most of working life. DD NOT use retired) anager	Amtran Courier
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica fo Be Comple	Benny Porter	Marion Jo	
MD 21 nd 2 should alth and Men 27 is man aumatic ev	Marion Porter-mother	b Mailing Address (Street and Number or Rural F B Fernsell Court-1D-Rose	edale,Maryland 21237
Baltimore, MD 21215 permit Pages I and 2 should be fill Department of Health and Mental H Important: If item 27 is marked injury or other traumatic event, it	1 XBurial 2 Cremation 3 Removal from State Garage 4 Donation 5 Other Specify:	of Disposition (Name of cemetery, inversely 1973) pate 1974 1975 1975 1975 1975 1975 1975 1975 1975	7 Rosedale, Maryland
Balti permit Departr Import injury	21 Signature of Funeral Service Licensee and all hold	22. Name and Address of Facility  ANS FUNERAL CHAPEL  AND CREMATION SERVICE	
Physician /Medical	23a. Part I. Enter the disease, or complications that caused the death. Do n failure. List only one cause on each line.		oiratory arrest, shock, or heart  Approximate Interval Between Onset and Death
:aminer	Immediate Cause (Final disease or condition resulting in death)  a. Hypertensive cardiov  Due to (or as a consequence of):	vascular discose	
iner	Sequentially list conditions, if any, leading to immediate Cause. Enter Underlying Cause		
58760, ST Tifficate be executed ling physician and as the burial - transit an/Medical Examine	(Disease or injury that initiated events resulting in death) Last  C.  Due to (or as a consequence of):  d.		
760, icate be executly physician and the burial - tra	X UNPENDED AMENDED #23a,27, perME, g869	9, 7/6/07 TT	
Division of Vital Records, P.O. Box 68760, For the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transing edical Certification: To Be Completed by Physician/Medical E.	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 4 Pregnant at time of death g Unknown	Fetal death 3 Ectopic pregnancy  Other (Specify)	23d. Date of delivery  Month Day Year
O. B at the d d by the etached:	Part II. Other significant conditions contributing to death but not resulting	ng in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
ds, P.C quires that en signed uld be dets			1 Yes 2 No 3 Probably 4 V Unknown  24a. Was an 24b. Were autopsy findings available
Division of Vital Records, P.O. Ital or stending Physician: The law requires that the safter death.  The Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacertification: To Be Completed by F			autopsy performed? prior to completion of cause of death?  1 V Yes 2 No 1 V Yes 2 No
tal R cian: 1 certific ector, p	25. Was case referred to medical	26.Place of Death (Check only of Dutpatient 3 DOA Other Nursing Ho	
of Vig Physic ter this eral dir	1 Yes 2 No Inpatient 2 ER/C		me 5 Residence 6 🗸 Other: Scene  Describe how injury occurred
ion c tending eath. for: Af the fun	1 Natural 5 Pending (Month, Day,Year)  2 Accident Investigation	1 Yes 2 No	
Division o Spital or Attending sours after death. neral Director: Aft filled in by the fune Certification:	3 Suicide 6 Could not be determined (Specify)	farm, street, factory, office building, etc. 28f.	Location (Street and Number or Rural Route Number, City or Town, State)
Division of Vital Records, P.O. Box 6  To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attend completely filled in by the funeral director, page 2 should be detached for use Medical Certification: To Be Completed by Physicis	29a. Certifier Certifying Physician: To the best of my knowledge, de one) 2 Medical Examiner: On the basis of examination and/or and manner stated.	eath occurred at the time, date and place, and due investigation, in my opinion, death occurred at the	to the cause(s) and manner as stated. time, date and place, and due to the cause(s)
	29b. Signature and title of certifier	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year)  June 28, 2007
Ø	30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111	J ) I Penn Street, Baltimore, MD 21201	
State			
Registra	1111 0 5 2007 125	Brack )	

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 🚄 1. Decedent's Name (First, Middle, Last) 2. Date of Death HULAM LEME 4a. Facility Name (If nqt institution, give street and number) 4b. City, Town or Location of Death 4c. County of Death andallstow If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 025 1 □ M 2 💢 F Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits Baltimore 1 ☐ Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Featherhed Lane Apt 126 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: Specify: Black 1 ☐ Yes 2 🕱 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Baltimere County Public Schal 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Parish Dixie Walker Mamie 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 98 Dunhill Village Apt 101 Boutimore MD 31244 of Disposition (Name of Date 20c. Location - City or Town, State Franklin Pulliam 1 Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify) 3 □Removal from State Park :07.06.2007 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Varyan C \$728 Liberty IZd . Green puneral service 23a. Part1. Enterthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last puentially list conditions Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 Yes 2 No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed3 1□ Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No

**Physician** /Medical Examiner

**Physician** 

Examiner

Director

Funeral

δ

Completed

Be

MI

**Funeral** 

Director

show aţ r 28a-f sh notified

permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or any Injury or other traumatic event, the Medical Examiner must be a

Maryland 21215-0036

Baltimore,

/Medical

requires that the death certificate be executed

Examine

Physician/Medical

Completed

Be 2

Certification:

Medical

27. Manner of Death

1. Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

sician and burial-trans attending physician for use as the buria ed by the a detached i signed t certificate

within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir

To the Hospital or Attending Physician:

Division

or Vital Records, P.O. Box 68760,

State Registrar

L				26.	Place of Deat	th (Check	k only one)		
	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient	3□ DOA	Other: 4	I ☐ Nursing He	ome 5[	Residence	6 □Other (Specify)	
tion	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	M 28c	Injury at Work? 1 ☐ Yes	2 □ No	28d. De	scribe how inju	lry occurred	
t be ed	28e. Place of injury - At h building, etc. (Speci	ome, farm, street	t, factory, o	ffice		28f. Loc City	ation (Street a y or Town, Stat	nd Number or Rural Route Number, le)	

1 Certifying Physicia	n: To the best of my kr	owledge, death occu	irred at the time, date and place,	and due to the	cause(s) and manner as sta	ated.
	On the basis of examir and manner stated.	nation and/or investig	ation, in my opinion, death occurr	red at the time	, date and place, and due to	the cause(s
title of certifier a	and manner stated.	A	29c. License number		29d Date signed (Month I	2- 141

1		1
29b. Signature and title of certifier	1	/
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	THE V	XXX TRAK

0052760

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

5 Pending investiga

6 Could no

determin

32. Registrar's Signature

Eardallstoum MD 21133

			1 - For State Registrar	State of		d / Depa		of Hea	aith ar			giene	•	213	592
			Hegistrar     Decedent's Name (First, Middle, Last	:#)			incate	01 00	Julii		2. Date of Dea	Reg. No.		3. Time	of Death
	Physici				DDTMC					1	Month June 2	Day	2007 Yea	r	00 а <sup>м</sup>
	/Medic		BASILIA HOMES  4a. Facility Name (If not institution, give		DDING		4b. City, To	own, or Lo	cation of	Death	Julie 2		County of De		
	Examir	ier			001)		Belt			Dodin		Prince Geor			s
	Funeral		Hillhaven Nursing 5. Social Security Number 6. S		. Age (In yrs.	last birthday)	If Under 1		Under 2	4 Hrs.	8. Date of Birt (Month, Da			Birthplace (State Country)	
	Funeral Director			□M 2 <b>∑</b> F	86	Yrs.	Months (	Days F	Hours	Min.	06-14-	y, Year) 1921	Ph	Country) illippin	es
			Usual Residence of Decedent												
	ylan		10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside	
	a-f s	ctor	Maryland Prince	George's	Ну	attsvi	11e							1 X Ye	s 2 No
	or 28	Jr.	10e. Street and Number	11 197	101	-	10f. Zip C					10g. Citi	zen of What	Country?	
	23a	Funeral Director	5821 Queens Chape	el Road			2	0782				U.S	S.A.		
	eems erms	nei	11. Marital Status	12. Was Deced Armed Ford	es?	.S. 13.	Was Deceder	nt of Hispa Cuban, M	anic Origi Mexican,	n? (Spe Puerto F	cify Yes or No Rican, etc.)	-	14. Race - A Black, W	merican Indian, hite, etc.	
36	or II	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 If Yes, Give		1	1 ☐ Yes 2 🕽						Specify:	Filipino	)
8	thin 72 hours after death with the Maryland e. Medical Examinat must be notified at Medical Examinat must be notified at	d b	3 ₩ Widowed 4 Divorced	Year or Dat	les:	10: 0:	d	^				105 16			
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9	Hygi thar int.	ŭ	17. Father's Name (First, Middle, Last)			Nuls	IIIE No			s Name	(First, Middle,			Itai	
an	d be antal	To Be	Alejo E. Homeres						Pati	rici	a Malat	:e			
Maryland 21215-0036	should be nd Mental markad o	F	19a. Informant's Name/Relationship (	Type, Print)		19b. Mailir	ng Address (S	Street and			l Route Numbe		r Town, State	e, Zip Code)	
$\mathbf{z}$	parmit. Pages 1 and 2 should be Department of Health and Menta Important: If itam 27 Is marked any injury or other traumatic a <u>once</u> .	1 13	Amabel L. Landen	- Daugh	ter	1450	9 Colo	nel (	Conte	ee C	ourt, l	Jpper	Marl	boro, M	D 20772
ā,	Hea Hea tam		20a. Method of Disposition		20b. F	Place of Dispo	sition (Name	of	1		ate			or Town, State	
Baltimore,	age ant of st. If i		1 X Burial 2 ☐ Cremation 3 ☐  1 4 ☐ Donation 5 ☐ Other (Specify		tate	emetery, crei	-		<u> </u>	7_10	-2007	Δ×1	inaton	, Virgi	nia
	artme ortar injur		21. Signature of Euroral Service Lice		ALL		2. Name and			7-13	-2007			1timore	
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			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that car	used the deat	-								Approxim	ate
	Dhusisian		Immediate Cause (Final											Onset an	d Death
	Physician /Medical		disease or condition resulting in death)	u	rdial rasaconseq		tion				<u>_</u>			Sudde	n
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89	eath certificat attending phy I for use as thi	Medi	LE FENNIE									-			
Box	h cer endir r use	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	ome of pregna th 2 ☐Feta		DEctopic preg	nancv				:	23d. Date of	-	
	deat	sicle	in the past 12 months? 1 ☐ Yes 2 🌠 No		nt at time of d		Other (spec					100	Month	Day	Year
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	es tha igned I be det	by F	Part II. Other significant conditions of	ontributing to dea	ath but not res	ulting in the u	nderlying cau	ise given i	in Part I.					e to the cause o	
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Ä	The I	mo;									perfo	rmed?	death	1? ∕es 2□ No	
ita	ian: T artificat ctor, pa	Be (	25. Was case referred to medical examiner?					26	6. Place o	of Death	(Check only o	ne)			
of V	Physician: this certific ral director,	인	1 ☐ Yes 2 X No	Hospital: 1 ☐ In	patient 2	ER/Outpatier	nt 3 DOA	Other:	4 🔯 Nurs	sing Hor	ne 5□Resi	dence	3 □Other (S	specify)	
		ü	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of (Month	Injury , <i>Day Year)</i>	28b. Time o Injury	f 280	:. Injury at Work?		2	28d. Describe	now injur	y occurred		
Sio	Attanding r death. actor: Afte	catl	2 Accident investigation				М	1 TYes	s 2□N						
Division	If or Attand after death Diractor: /	Certification;	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	289. Place 0	of Injury - At ho g, etc. (Specif		reet, factory,	office		2	28f. Location (. City or To			Rural Route No	ımber,
	To the Hospital or A within 24 hours after To the Funeral Dira completely filled in b									<u> </u>					
	Hospital Puneral Funeral	edical	29a. Certifier 1 Certifying Ph (Check only 2 Medicel Exer	ysician: To the b niner: On the bas	pest of my kno sis of examina	owledg <b>e</b> , deat ition and/or in	h occurred at vestigati <i>o</i> n, ir	the time, my opini	date and ion, death	place, a occurre	and due to the ed at the time,	cause(s) date and	and manner place, and o	r as stated. due t <i>o</i> the cause	3(S)
	the the	Med	29b. Signature and title of certifier	and manne	er stated.		290	License nu	umber			29d Dat	e signed (M	onth, Day, Year,	}
	To With		230. Signature and the of certified	100	,										1
,			Marko	10/2				3233				Jun	e 28,	2007	
(	ø		30. Name and address of person who					C	to 21	20	C+1++	Cn~	ing M	ന ഉവരവാ	_5276
	Sta	at a	Suresh K. Gupta, 31. Date filed (Month, Day, Year)		gistrar's Signa		venue,	Sul	Le Z	۷,	errver	SPE	riig, M	D 20902	-5410
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Itanella 1:05 AM 2007 MCIG /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number **Examiner** 1912 Tree Line Dr. Forest Hill Harford 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 📉 F 54 95 4New Jersey 154449940 Director .20 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a, State r 28a-f show notified at Harford Forest Hill MD 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or items in items 27 is marked other than "natural", or items 23a or items injury or other traumatic event, the Medical Examiner must be none. 1912 Tree Line Dr. 21050 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14 Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) McCormick College (1-4or 5+) Elementary/Secondary (0-12) Accounts Payable Rep. 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Francis Cicio Mary Starrett 19a. Informant's Name/Relationship (Type. Print)
Nicholas Saltarella/Spouse 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1912 Tree Line Dr. Forest Hill, MD 21050 Baltimore, 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Bel Air Memorial 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 7/3/2007 Bel Air, MD Gardens 22. Name and Address Pureral Chapel & Cremation Services 21. Signature of Funeral Service License Bel Air 3 Newport Drive Forest Hill, MD 21050 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 5.5 year **Physician** Non-small 00 1 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical the attending pl 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1XYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performe 2**X**1No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2**2** No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Medical Certification: Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident after death | Director: ... d in by the f 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours aft.

To the Funeral Di
completely filled in 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Cherles Rd. MP 14/29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 02, 2007 DO061040 Arrociate Profi of Oncolo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 30 1550 Orleans St. Belhowe MD MOPLD 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 2007 0 5 Registrar JUI

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician 0003 M 2007 Loren Albert Shinneman /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Sinai Hospital Of Bultimore Baltimore N/A If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 1-okeNA. Shinn **Funeral** Days Hours 1000MM 2□F Director 486-16-4791 Dec. 10,1922 St. Louis MO. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at 1 ☐Yes 2√ No Director York County York 28a-f 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? 'natural", or Items 23a or 1301 Clover Lane 17403 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Til XYes 2 □ No W•W•II If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White þ 3 Widowed 4 Divorced Patient Known as Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Jack Adams Associates 12 04 Advertizina 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be fi Albert Shinneman Minni Tourville 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) is 1 and 2 of Health a Item 27 is Ms. Lori A. Blank (Daughter) 4514 Coffee Tree Court Pikesville,MD. 21208 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 permit. Pages Department of It Important: If it any injury or c 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Evans Funeral Chapel July 05,2007 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, MD. 22. Name and Address of Facility
Peaceful Alternatives Funeral&Cremation Ctr., P.A. 21. Signature of ral Service License 2325 York Road Timonium, Maryland lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death sho 7, or heart failure Immediat Cause Fina cardiothrombotic event **Physician** /Medical resulting in death) Due to (or as a consequence of): Examiner preumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed ASEVD. and Due to (or as a consequence of): attending physician a for use as the burial-1 Box 68760. Physician/Medical IE FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 5 Other (specify) P.O. I 1 ☐ Yes 2 ☐ No the 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. or Vital Records. 1 Yes 2 No 3 Probably 4 Miknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed certificate 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Tes 20 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 [Inpatient 2 ER/Outpatient 3 DOA မ After this funeral 27. Mann of Death 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1 Natural (Month, Day Year) 5 Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 2 Accident illed in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) nothing upriling in 00057465 7/3/07 MEDICINE ATTENDINE 25 MAIN St. / Suite 700, Resstendan, MD. 2/134 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N.S. Ray WPAKEMD 32. Registrar's Signature 31. Date filed (Month, Day, Year) JUL 0 5 2007 Registrar

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r 28a-f sh notified

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Department of Health a Important: If item 27 is any injury or other trau

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Director

Funeral

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Completed

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filed within 72 hours after death with the Maryland Hygiene.
Hyener than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

Box 68760.

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Division or Vital Records,

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After t

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after death

within 24 hours at To the Funeral C Hospital

Examiner Physician/Medical þ Completed Be ၉ Certification:

IF FFMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

29a. Certifier

(Check only one)

25. Was case referred to medical examiner' 1 Yes 2 No 27. Manner of Death

1. Natural 5 ☐ Pending investigation 2 Accident 3 Suicide 4 Homicide

6 ☐ Could not be

28a. Date of Injury (Month, Day Year) 28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the death occurred at the time, date and place, and due to the cause(s) and due to the cause(s).

29b. Signature and title of certifier 30. Name and address of person who comp eleted cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

KUNAID State

Registrar

Medical

31. Date filed (Month, Day, Year) JUL 0 5 2007 3 Registrar's Signature

and manner stated.

821 N. EUTAN ST #202

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July Day **Physician** 20°0°7 1 0440 а м Swann Mary Elizabeth /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Highland Howard 13015 Route 108 if Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye Apr. 16, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year, Days Hours 1919 Washington, DC 1 ☐ M 2 💢 F 88 214-38-3067 Director Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show the Mcdical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Highland MD Howard 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 20777 U.S.A. 13015 Route 108 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours atter of Department of Health and Mertal Hygiene. Important: If item 27 is marked other than "natural", or iten any inJury or other traumatic event, the Mcdi.al Examiner any inJury or other traumatic event, the Mcdi.al Examiner. 1 Never Married 2 Married 1 ☐ Yes 2XXXVo Baltimore, Maryland 21215-0036 Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Ervin Eaton Kinzer Esta Puffenberger 2 19a. informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13015 Route 108 Highland, Maryland John T. Swann husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 7/3/2007 St. Mark's Cemetery Highalnd, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Donaldson Funeral Home, P.A. M00770 313 Talbott Avenue Laurel, Maryland 20707 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 23a. Part1. Enter the disease, shock, or heart failure. L. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner many he Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the death certificate be executed buriaf-transit and Due to (or as a consequence of) physician Physician/Medical use as the IF FEMALE 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Month Day in the past 12 months? 4□Pregnant at time of death 5 Other (specify) I ☐ Yes 2 ☐ No the detached 9□Unknown 9 \ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ should be 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy perform 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 □Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3□ DOA Certification:

Division or Vital Records, P.O. Box 68760. After this certificate the funeral director. To the Hospital or Attending 24 hours after death e Funeral Director: filled in by within 2

28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainer as solded.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month. Dav. Year)

ted cause of death (Item 23a) (Type, Print) 30. Name and address of person who

4801 Dorsey

31. Date filed (Month, Day,

32. Digistrar's Signature

4

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 007 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician burrier 0004 Jul 2007 /Medical 4c. County of Deat 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner JOHNS HODKING HOSSITA1 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** 1 M 2 TF Feb 12 1929 Director 212-26-8680 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits 10a. State 10b. County 28a-f show Baltimore 1 √Yes 2 No 7 is marked other than "natural", or items 23a or 28a-f st traumatic event, the Medical ExamIner must be notified Director Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number US 7602 Clays Lane 21144 Apt 118 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Specify: White ≥ 3 ₩Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wi Department of Health and Mental Hygien. Important: If item 27 is marked other tha any Injury or other traumatic ender. 12 Homemaker Her Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Florene E. Dev William A. Loats ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3801 Ridgecroft Rd., Baltimore, MD <u> 21206</u> David Spurrier 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Jul 6 2007 Woodlawn, MD Lorraine Park Cemetery 22. Name and Address of Facility Burrier-Queen Funeral Home ature of Funeral Service Incense 1212 W. Old Liberty Road, Winfield, MD 21784 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause — each line. a. Part1 Enter the disease, or conshoo, or heart failure. List only Immedian Cause (Final disease or condition resulting in death) **Physician** day /Medical Due to (or as consequence of): Examiner -operative Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner for use as the burial-trans that initiated events resulting in death) Last Due to (or as a conseque nce of) attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 No Day 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a P.0. 9∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 2 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown page 2 should I Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1□ Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No npatient P 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 5 ☐ Pending investigation 1 Natural To the Hospital or Attendia within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NAHAPVINE PESCE 600 N. Wolfe St. Baltimore 31. Date filed (Month, Day, Year) 32. Registrar's Signature 0 5 2007

DHMH 17 Rev 1/2001

Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1 - State Registrar	Cei	rtificate of L	Death	R	eg. No.	001	C. I.	) ) 0
Physic	ian	Decedent's Name (First, Middle, Last)     PETER JOSE	PH SAI	PTFN7A		2. Date of Dea	th Day	Year	3. Time of	
/Medi			TII DAI			June 30	), 2		9:10	Рм
Exami	ner	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Pasa	adena	n		County of Dea Anne Ar		
Funeral		168 OakDrive 5. Social Security Number 6. Sex 7. Age (In yrs. Ia	ast birthday)			8. Date of Birth		9. Bir	thplace (State of	or Foreign
Director		218-05-5727 <sup>1⊠M 2□ F</sup> 89	Yrs.	Months Days	Hours Min.	Oct 16			ountry) ennsylva	nia
and		Usual Residence of Decedent  10a. State 10b. County 10c. City,	Town or Lo	ocation	<u>.                                    </u>				10d. Inside Ci	ity Limits
Maryl -f sho	ō	Maryland N/A		Ba	altimore				1 <b>K</b> iYes	2 No
h the rr 28a	Director	10e. Street and Number		10f. Zip Code		1	0g. Citiz	en of What Co		
uth wit 23a c ust be		600 Light St., #502			21230				USA	
er dea Items	Funeral	11. Marital Status  12. Was Decedent Ever in U.S Armed Forces?	3. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (S n, Mexican, Puer	pecify Yes or No- to Rican, etc.)	1	<ol> <li>Race - Ame Black, White</li> </ol>		
aryland 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. r marked other than "natural", or items 23a or 28a-f show umatic event, the Medical Examiner must be notified at	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give 3 ☑ Widowed 4 ☐ Divorced Year or Dates:		1 ☐ Yes 2 🕱 No	Specify:			Specify: V	White	
2 hou	ted	15. Decedent's Education	16a. Dece	dent's Usual Occupa	ation	at do a		d of Business	/Industry	
215 Iffriin 7 Dan "r	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)		kind of work done of DO NOT use retired,	) )	King		hlehem el Corr		
High w		O U  17. Father's Name (First, Middle, Last)	<u> </u>	oe Fitter	19 Mother's Nar	ne (First, Middle, i			•	
Maryland 21215-0036 Id 2 should be filed within 72 hours at Ith and Mental Hygiene. 27 Is marked other than "natural", or traumatic event, the Medical Exami	o Be	Agostino Sapienza		,		,	Bonn	,		
Shoul nd Me mark	2	19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ng Address (Street a					Zip Code)	
re, Maryla s 1 and 2 should f Health and Men item 27 Is marke other traumatic		Catherine J. Creighton (Daughte	r) 12	270 Rivers	side Ave	., Baltin	ore	, Maryl	and 212	:30
altimore, mit. Pages 1 ar partment of Hea portant: If item 3 y Injury or other		TIA Burial 2   ICremation 3   Themoval from State 1 _		sition (Name of matory or other place			20c. Loc	cation - City or	Town, State	
timor  T. Pages tment of light		4 □ Donation 5 □ Other (Specify) G1e		en Mem Pk					e, Maryî	Land
Baltimore, permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other once.		21. Signature of Funeral Service Licensee Kevin E Ecke	1	McCully-Po	olyniak	Funeral 1	Home	, P.A.		
		23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.	Do not ent	130 E. For	rt Ave., g. such as cardia	Baltimo:	re. est.	Md = 2	Approximat	e
Physician	١,	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final	46:	Bladu	1 6				Interval Bet Onset and I	ween Death
/Medical		disease or condition resulting in death)  a. Due to (or as a consequence)		1714214	er a	com	_		mu	16
Examiner	Ι.	Sequentially list conditions b.								
ed isit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that interested one or injury	inge of):							
I <b>Records, P.O. Box 68760,</b> The law requires that the death certificate be executed at has been signed by the attending physician and bage 2 should be detached for use as the burial-transit.	Examiner	that initiated events resulting in death) Last C Due to (or as a consequ	ence of):	<del></del>						
68760 fircate be e physician ts the buri		d								
x 68 certifica ling ph	Medical	IF FEMALE:								
BOX leath ce attendi		23b. Was decedent pregnant 1 Live birth 2 Fetal	death 3	Ectopic pregnancy			2	3d. Date of de Month	-	Year
at the de	Physician/	1 □ Yes 2 ☑ No 9 □ Unknown 4 □ Pregnant at time of de	ath 5L	Other (specify)					,	
IS, P.		Part II. Other significant conditions contributing to death but not result	ting in the u	nderlying cause give	en in Part I.	23e. Did tol	oacco us	se contribute to	o the cause of c	leath?
Cords w requires been sign should be	ed by					1 🗆 Y	es 2	No 3□P	robably 4 □	Jnknown
eco law re as bee	Completed					24a. Was a		24b. Were a	utopsy findings completion of c	available
The The page	E					perfóri	ned? 2 12 No	death? 1 ☐ Yes		adde of
Vital Records, sician: The law requires the certificate has been signed rector, page 2 should be or	Be	25. Was case referred to medical examiner?		Otho		ath (Check only on			ns Resi	dence
Phys rthis	- To	To res 2 la No	R/Outpatier 28b. Time of	nt 3□ DOA Othe	4 LJ Nursing F	fome 5 ☐ Reside		Other (Spe	ecify)	
DIVISION OF  I or Attending Phy after death.  Director: After this d in by the funeral di	tion	1 ☑Natural 5 ☐ Pending (Month, Ďay Year) 2 ☐ Accident investigation	Injury	f 28c. Injury Work M 1 □ \	k? Yes 2 □ No					
VIS	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At hor building, etc. (Specify,	ne, farm, str	eet, factory, office		28f. Location (Si City or Town	reet and	Number or R	ural Route Num	nber,
ital or ral Di	Se									
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifice completely filled in by the funeral director, to	edical	29a. Certifier 1 Certifying Physician: To the best of my know (Check only one) 2 Medical Examiner: On the basis of examination and manner stated.	/ledge, deat on and/or in	h occurred at the tim vestigation, in my op	ne, date and place pinion, death occ	e, and due to the c urred at the time, c	ause(s) ate and	and manner a place, and du	s stated. e to the cause(s	3)
ro the vithin somple	Med	29b. Signature and title of certifier		29c. License	number	2	9d. Date	signed (Mon	th, Day, Year)	
1		Mullen	un	0	30555	-	hul	3,	2007	
		30. Name and address of person who completed cause of death (Item	23a) (Type,	Print)			/	,		
1		31. Date filed (Month, Day, Year)  32. Registrar's Signati	10( / <u>5</u>	act fwi	/tre	Balton	res	ins	2/27	20
St Regist	ate rar	JUL 0 5 2007	H.	Print)  act FwT						
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** June : 23.4 200 0 28 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and numb 4b. City, Town, or Location of Death **Examiner** Franklin Sqaure Nursing Home Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex M 2□ F 7. Age (In yrs. last birthday) **Funeral** Min Months Days Hours Director 220-36-4037 65 Dec. 6, Maryland Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10a. State 10b. County ar than "natural", or Itams 23a or 28e-f show It e Modical Examiner must be notified at 1 ☐ Yes 2 No Director Baltimore MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21236 United States 3829 E. Joppa Road, Apt T-2 Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 No 1960 If Yes, Give Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White Specify: 3 Widowed 4 Divorced 1969 Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7;
Department of Health and Mental Hygiene.
Importent: If itam 27 is marked other than "nu any injury or other traumatic avant, ILe Madis, 2028. Elementary/Secondary (0-12) College (1-4or 5+) Law Enforcement Physical Science Technician 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lilly Marshall Harold Sheppard, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Leah Sheppard - Wife 3829 E. Joppa Rd., Apt T-2, Baltimore, MD 21236 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of West Arundel 1 ☐ Burjal 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) } Crematory 22. Name and Address of Facility 7-4-2007 Odenton, MD 21. Signature of Funeral Service Licens Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part1. Enter the disease, or complications that eaused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death eaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) non Small Pnysician 70 cell /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of). Examine ed by the attending physician and detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. death certificate be Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 4☐Pregnant at time of death 9 Unknown cate has been signed by , page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an anemia autopsy performed? 1 ☐ Yes 2 No To the Hospital or Attanding Physiclen: funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification; To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Mannes of Death 28b. Time of After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after deatl To tha Funaral Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie nondas 111 1941 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) dwondson Franklin 31. Date filed (Month, Day, Year) State JUT 0 5 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 1 per doc 8869 7-6-07 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Jitendrabhai Soni 1. Decedent's Name (First, Middle, Last) Bhanumati Day Year Physician JUI 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death cility Name (If not institution, give street and number) Examiner len lod Durw Date of Birth (Month, Day, Year) Under 1 Year Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, **Funeral** Months Days Hours Min. 1 ☐ M 2 💢 F Yrs. 8, 1943 India Director Sept. 56-17-9353 63 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show r 28a-f show notified at 1 ☐ Yes 2 🔀 No Director Bridgewater Somerset New Jersey 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be a India 08807 33 Colmart Way Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No if Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: ģ Asian-Indian 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Own Home 12th Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be 1 nent of Health and Mental I Kamlaben Soni ပ္ Ambala1 Soni 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Bridgewater, New Jersey 08807 33 Colmart Way Jitendra Tribhuvandas Soni/spouse 27 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Important: If it any injury or o West Arundel Crematory 7/3/2007 Odenton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on eigh line.

Immediate Cause (Final disease or condition resulting in death) permit. 22. Name and Address of Facility Donaldson Funeral Home & Crematory, Odenton, Maryland 21113 Approximate Interval Between Onset and Death **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day in the past 12 months? 1☐ Yes 2 No 9☐ Unknowh 4 Pregnant at time of death 5 ☐ Other (specify) ed by the a 9□ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Nnknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autonsy page perform 2 No certificate 1 2 No ector, 26. Place of Death Check onl one 25. Was case referred to medical Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2□ No 1 Inpatient 2 ER/Outpatient 3□ DOA မ this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification; After 1- Natural 2 ☐ Accident 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 1 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

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30. Name and address of person who completed

JUL 0 5 2007

Villiam

31. Date filed (Month, Day, Year)

se of death (Item 23a) (Type, Print)

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32. Registrar's S

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Time of Death **Physician** Ju<sub>1</sub>y 2007 07:33a <sup>M</sup> **EDITH SCHOCHET** 01 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 6. Sex 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 □ Director 219-16-8708 82 01/29/1925 MD Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d, Inside City Limits 10h. County "natural", or Items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 No Director **BALTIMORE** MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7202 ROCKLAND HILLS DRIVE #305 21209 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. int: if Item 27 Is marked other than "natural", or Ite 1 Never Married 2 Married 3 Widowed 4 Divorced WHITE 1 ☐ Yes 2 🛣 No Specify. If Yes, Give Year or Dates Completed by altimore, Maryland 21215-003 event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be GILDEN SARAH POTASH SAMUEL ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LOUIS SCHOCHET / HUSBAND 7202 ROCKLAND HILLS DRIVE #305-BALTIMORE, MD 21209 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Important: if It any Injury or c 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) **WORKMENS CIRCLE** 07/03/2007 | BALTIMORE, MD SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service License 22. Name and Address of Facility 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition **Physician** Dehydration resulting in death) /Medical Due to (or as consequence of): Examiner predst cancer Metastatic Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to (or as a nonsequence of) Physician/Medical Examiner certificate be executed and-tran Due to (or as a consequence of): physician ar s the burial-t as IF FEMALE: nse 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ▼ No 23c. If yes, outcome pf pregnancy 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy Month 5 ☐ Other (specify) Division or Vital Records, P.O. been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by woematronia. 1 Yes 2 No 3 Probably 4 Unknown Post-obstructive oneumonia: weokalonia 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy performe page certificate 1□ Yes 2X No director, 25. Was case referred to medical examiner? To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Inpatient 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation (Month, Day Year) Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident s after death. I Director: A of in by the for 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours and To the Funeral Dir 🗽 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00060547 MD JUN 1, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

Maryjoy Meila

31. Date filed (Month, Day, Year)

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32 egistrar's Signature

North charles Street Baltmore,

Maryland 21204

			For State of Mary		artment of H rtificate of L			jiene leg. No. 200	7 01600
			1. Decedent's Name (First, Middle, Last)				2. Date of Dea	th	3. Time of Death
	Physici /Medi		Cordelia Ruby Towson				Month 6	Day Yea 200	
	Examir		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death		4c. County of De	ath
	¥4,		Stella Maris Hospice			onium If Under 24 Hrs.	0.00.1		ltimore
	Funeral		1 □ M <b>X</b> (X)F	yrs. last birthday) 89 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day	9. B	irthplace (State or Foreign Country)
	Director		212-07-8161 Usual Residence of Decedent	09			10/12/	/191/   Ma	ryland
	yland Jow			c. City, Town or Lo	ocation				10d. Inside City Limits
	e Mai la-f si tiffied	ctor	MD Baltimore	Cockey	sville				1 ☐ Yes 2 ☑ No
	ith th	Director	10e. Street and Number		10f. Zip Code			10g. Citizen of What	Country?
	ath w s 23a nust b	ral	16 galetree Court		21030			USA 14. Race - An Black, Wi	agrican Indian
	items items	Funeral	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 1 □ Yes 2 ☑ No	in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Spe n, Mexican, Puerto	Rican, etc.)	Black, Wi	nite, etc.
36	urs af	by F	3 Widowed 4 □ Divorced Year or Dates:		1 ∐Yes 2. ZANo	Specify:		Specify:	White
ŏ	72 hours after death with the Maryland natural", or items 23a or 28a-f show Jical Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occupa	ation	200	16b. Kind of Busines	s/Industry
215	thin 7	lg l	Elementary/Secondary (0,12) College (1-4or 5+)	life.	kind of work done d DO NOT use retired,	)	'y		
2	led will lygier ner th	ပိ			Homemake	<u>r</u> 18. Mother's Name	/Fine Add della		dence
. Pu	be fill Had Had ott	Be	17. Father's Name ( <i>First, Middle, Last</i> )  Raymond Bowers					,	
N. Z	hould d Me nark natic	ဥ	19a. Informant's Name/Relationship (Type. Print)	10h Maili	ng Address (Street a		ian Ruk	r, City or Town, State	Zin Code)
5 P.M. Maryland 21215-0036	nd 2 s lith an 27 is i		Penelope Villa/ daughter	1				, MD 2103	
:45	f Hea f Hea item			I			ate	20c. Location - City	
3:4 Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		Magazial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation from State Magazine from S	Dulanéy Jemoriai	osition (Name of matory or other place Valley gardens	July 2007	2,	Timonium	, MD
alti	permit. DepartmImporta any Inju		21. Sign was uneral Service Licensee	2	2. Name and Address ans Funer	s of Facility	_88	300 Harfor kville, M	
ω	De B E G		Wet O Sill	6	crematio	n Service	es :		D 21234
			23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	death. Do not en	ter the mode of dying	g, such as cardiac o	or respiratory ar	rest,	Approximate Interval Between Onset and Death
اع	Physician		Immediate Cause (Final disease or condition		RDIAL				Onset and Death
9	/Medical Examiner		resulting in death)  Due to (or as a co	nsequence of):					
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19	uted	Ë	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  C						
3, 2007 <b>68760.</b> E	exect an and rial-tra	edical Examiner	resulting in death) Last Due to (or as a co	nsequence of):					
26	ate be nysicia ne bu	ical	d						
29, x 68	ing ph	Med	IF FEMALE:						
0	ath ce ttendi or use	an/	23b. Was decedent pregnant 1 Live birth 2	Fetal death 3	⊒Ectopic pregnancy			23d. Date of o	delivery Day Year
2 .	70 0 70	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	of death 5L	Other (specify)				2,
JU. 9	that the ed by detac	, Ph	Part II. Other significant conditions contributing to death but no	ot resulting in the ι	Inderlying cause give	en in Part I.	23e. Did to	bacco use contribute	to the cause of death?
TOWSON Vital Records	quires n sign lid be	d by					1 🗆 Y	′es 2 No 3 □	Probabły 4 □Unknown
≥ Ö	s beer	Completed					24a. Was a	an 24b. Were	autopsy findings available o completion of cause of
TOWSON	The Is te has	mo Dimo					autop perfor 1∐ Yes	med <b>≆</b> ∣ death	o completion of cause of ? es 2 ☐ No
T∂k ital	lan: rtifica stor, p	BeC	25. Was case referred to medical			26. Place of Death			2 110
-	hysic his ce I direc	70 E	examiner? 1   Yes 2   No   Hospital: 1   Inpatient	2 ER/Outpatie	nt 3 DOA Othe	er: 4 Nursing Ho	me 5 Resid	lence 6 □Other (S	oecify)
CORDELIA	Ing P		27. Manner of Death 28a. Date of Injury 1 Natural 5 Pending (Month, Day Ye	28b. Time of Injury	Work		28d. Describe h	ow injury occurred	
RDI	tend leath. tor: /	cati	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of injury	At home form of		Yes 2□No	006 1	Name of Advantage of	Porel Paula Monta
CORDELIA Division or	or A after Direc	Certification:	4 Homicide determined 200. Flace of injury building, etc. (S	pecify)	reet, ractory, office		City or Tow	n, State)	Rural Route Number,
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.		29a. Certifier 1 T Certifying Physician: To the best of m						
	n 24 h n 24 h ne Fu oletely	Medical	(Check only one)  2 Medical Examiner: On the basis of examiner and manner stated.	mination and/or ir	nvestigation, in my o	pinion, death occur	red at the time,	date and place, and o	lue to the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier		29c. License			29d. Date signed (Mo	
			Dungarasanos MD		DI	6619		July 2,	2007
	2.0		30. Name and address of person who completed cause of death			73 7 7 77 7 7 7 7 7	1D ====	01/7/1/	27002
	12	ate	CORAZON VERGARA-SOARES, M.1 31. Date filed (Month, Day, Year) 32. Degistrar's	0'	DULANEY V	ALLEY RO	AU TIMO	ONIUM, MD	21093
	Regist		31. Date filed (Month, Day, Year)  32. Registrars:	H A	DENEL!				
			JUL 1 3 200.						

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3:45 P.M.

07-05008 Davon Leon Turner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2017 2150

	1- For State Registrar		Certi	ificate of	Death			Reg.	No.	_ U U	1 6100	
Physician/	1. Decedent's Name (First, I	vliddle,Last)						ate of Death	ay Yea		. Time of Death 0248 hrs	
ledical Examiner	ner Davon Leon Turner July 1, 2007							02461115				
	4a. Facility Name (if not inst 822 N. Patterson		umber)	4	4b. City, Town, or Location of Death  Baltimore  If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State							
Funeral	5. Social Security Number	6. Sex	7. Age (In yrs. las	st birthday)	If Under 1 Year		24Hrs. 8. E	Date of Birth	(MM/DD/YYYY	9. Birthp Foreign	place (State or	
Director	217-11-9237	1 XM 2 F	21	Yrs.		S Hours	MIII.	3-24-1986 Country) Md.				
Andrew Artists of the	Usual Residence of Deceder 10a, State 10b, Co		10c, City, T	Town or Location	on		<del></del>	-		1	0d. Inside City Limits	
ow any	Md.	NA	1001 011,71		imore						1 X Yes 2 No	
Maryland 28a-f show at at once.	10e. Street and Number				10f. Zip Code			10g	. Citizen of Wh	hat Countr	y?	
th the Maryland 23a or 28a-f sho notified at once.	725 N. Glov	er Street			21205	5			τ	USA		
s 23a			ecedent Ever in U.S		s Decedent of Hi	spanic Origi					n Indian, Black,	
r death with or items 23 must be no	1 Never Married 2	Married Armed	Forces?	If Ye	es, specify Cuba	n, Mexican,	Puerto Ricar	n, etc.)	White	e, etc.		
safter d		Divorced If Yes, Give You		1	Yes 2X No	specify:			Specify:	Bla		
hours after hours after hours after Examiner ted by	15. Decedent's Education			16a. Deceden	t's Usual Occupa ost of working life	tion (Give k	kind of work d use retired)	done 1	16b. Kind of Bu	usiness/Inc	dustry	
0036 within 72 hour giene. her than "natur Medical Exan	Elementary/Secondary (		(1-4 or 5+)	Ilnom	ployed				NA			
withi withi giene.	17. Father's Name (First, M			Orieni	7	18. Mother's	s Name (Firs	t, Middle, Ma	aiden Surname	3)		
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	~	,	Turner			Ro	bin		C.	Tho	mpson	
212 ould b I Memi in art ic eve	19a. Informant's Name/Rela				Address (Stre							
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re, s I and f Heal ff iten	20a. Method of Disposition  1 X Burial 2 Crer	nation 3 Removal		lace of Dispos rematory or oth	ition (Name of ce ner place)	emetery,	Dat		20c. Location	- City or 11	own, state	
Page nent o ant:	4 Donation 5 Oth	er Specify:	M	It. Zio		-	7_7_(	07	Lansdo	owne,	Md.	
Baltimore, permit. Pages I an Department of Hea Important: If iter injury or other tr	21. Signature of Funeral Se				lame and Addres	-	riai		H. East		21202	
	23a. Part I. Enter the disea		caused the death.	_							Approximate Interval	
Physician /M. dical	failure. List only one	cause on each line.	Sunshot Wound		, ,						Between Onset and Death	
aminer	Immediate Cause (Final di or condition resulting in de		a consequence of									
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± 22	(Disease or injury that initial events resulting in death)	ated Durate (as as	s a consequence of	):								
0, e be executed ysician and burial - transit		d										
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8760, ifficate be ng physic is the bur			s, outcome of pregr e birth	nancy <sub>2</sub> Fe	etal death 3	Ectopic	c pregnancy		Month	,	ay Year	
Sox 687 leath certifi e attending for use as t	past 12 months?	4 Pre	gnant at time of dea	oth	ther (Specify)							
P.O. Box 68 state the death certify med by the attending detached for use as two Divisional pays Divisional pa	Part II. Other significant	9 011	known	esulting in the	underlying cause	given in Pa	art I.	23e. Did tot	bacco use con	tribute to t	he cause of death?	
P.O. B es that the digned by the detached	2	endeninos enombles.	g to death but not re	Solung III alo	and anything dades	9					ably 4 Unknown	
Records, Progress of The law requires to ficate has been sign, page 2 should be							_ 3	24a. Was a			opsy findings available	
of Vital Records, ng Physician: The law require After this certificate has been signed director, page 2 should be	<u> </u>						<del></del>	autops	med?	death?	ompletion of cause of	
Vital Rec ysician: The l his certificate director, page		and incl			26 Pla	ce of Death	(Check only	1 Yes 2	2 No	1 Yes	s 2 No	
rital sician is certi	examiner?	Hospital:	Inpatient 2	ER/Outpatien		Other 4	Nursing Ho		Residence 6	✓ Other:	Scene	
n of Vi ding Physi a. After this funeral dir		28a. Da	ate of Injury	28b. Time of	Injury 28c. In	jury at Worl		d. Describe h	now injury occu	rred		
ion tendin eath. tor: A the fu	Natural 5 Accident	Pending Jul'1,	onth Day, Year) 2007	0238 hrs	1	Yes 2 🗸	No Sui	DJ <del>e</del> Ci was	51101			
Division tal or Attendi us after death. al Director: /	2 Accident 3 Suicide 6	Could not be 28e. P	lace of Injury - At ho	ome, farm, stre	et, factory, office	building, e		or Town, St	tate)		ral Route Number, City	
Division o Hospital or Attending 24 hours allore death rely filled in by the fune	4 V Homicide		fy) Local Stree			_		2 N. Patter	rson Park Av			
중축 등 등 2	29a. Certifier 1 Certify one) 2 Medic	ving Physician: To the lateral Examiner: On the bas	best of my knowledges of examination as	ge, death occu ind/or investiga	irred at the time, ation, in my opini	date and ploon, death or	ace, and due ccurred at the	e to the cause e time, date a	e(s) and mann and place, and	er as state I due to the	ed. e cause(s)	
2 # 2 # 2 # 2	29b. Signature and title of	and manne	er stated.			nse number					nth, Day, Year)	
	į.	1. 6.1	mo		0.0	C.M.E.			July 1, 20	07		
	30. Name and address of	person who completed o	ause of death (Item	n 23a)								
1		sistant Medical Ex	kaminer 111	Penn Stre	et, Baltimore	e, MD 212	201					
Star Registra		(Year) 32.	Registrar's Signatu	ure								
DHMH 17 Rev 1/200		U 9 FOOT 1	ienes (	ORIGINA	Al							
DI 11411 LT LVCA 1/500				CICIONAL	-							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 24a per doc 9869 7-17-07 vt. State of Maryland? Bepartment of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Days 2 (Vear **Physician** AROLYN 08,000M /Medical Facility Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL 6. Sex Bed timere handallstan 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday)
Yrs. Social Security Number Birthplace (State or Foreign Country) **Funeral** 212.42.9019 Usual Residence of Decedent Months Days Hours Min. 1 □ M 2 F 0. Director Maryland death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show ?7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medic ■ Examiner must be notified at 1 □Yes 2 No Director handaustan mD Baltimare 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21133 USA Travancore Moad Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 2 should be filed within 72 hours after and Mental Hygiene.

is marked other than "natural", or ite 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Processor 1ears Social Security 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any Injury or other traumatic ew Myrtle Simpsin Melius Barnes 19a, Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Travancore Read Mandallston mD 31133

Date 20c. Location - City or Town, State Husband mald lynes 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Pridal 07.07.2007 Bultimore, MD 22. Name and Address of Facility Vaughn C. Green Jurus Service 21. Signature of Funeral Service Licensee 23a. Part1. Enterine disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final EPSIS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner TRA ABDOMINAL INFECTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events southing in death). Due to (or as a consequence of) Examiner certificate be executed burial-tran and resulting in death) Last Due to (or as a consequence of) attending physician Box 68760. Physician/Medical the use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Ö in the past 12 months? Month Year Day 4□Pregnant at time of death 5 Other (specify) P.O. I signed by the a d be detached f 1 ☐ Yes 2 ☐ No 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, Š 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown DISSEMINATED INTOLOVASCUAR COAGULATION Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No NAUS ENYTHE MATUSIS 24a. Was an SYSTEMIC page 2 s has autopsy perform certificate Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Lopatient 2 ☐ ER/Outpatient 3 ☐ DOA မ this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending Division 1 Matural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number DS4288 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MO ly 18 2007 1 who completed cause of death (Item 23a) (Type, Print) lottined hyspital cante 10 amorrany Registrar's Signature 31. Date filed (Month, Day, State 2007 0 5 Registrar

07-04939

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

icholas A. Torre	1-	State of Maryland / I	Department Certificate	of Health and of Death	d Mental Hyg	giene Reg. N	200	7 2160
Physician		e <u>gistrar</u> . Decedent's Name (First, Middle,Last)				. Date of Death Month Da	y Year	3. Time of Death 1915 hrs
∕ledical Examine		NICHOLAS A .  a. Facility Name (if not institution, give street and number)	TORRE	4b. City, Town, or		June 28, 200	7 4c. County of Death	
		Baltimbre Washington Medical Center		Glen Burnie			Anne Arundel	
Funeral Director		5. Social Security Number 6. Sex 7. Age (	(In yrs. last birthday)	If Under 1 Year Months Days Yrs.		8. Date of Birth (N Feb. 10,	MM/DD/YYYY) 9. Bir 1983 Foreig	n Maryland
any		Jsual Residence of Decedent	0c. City, Town or Lo	ocation				10d. Inside City Limits
<b>*</b> .		Maryland Anne Arundel	1 Yes 2 No					
th the Maryland 23a or 28a-f sho notified at once.	ë	10e. Street and Number 2951 Almondbury Drive		10f. Zip Code 211			U.S.A.	
er death wi	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 3 Widowed 4 Divorced If Yes, Give Year	X No	Was Decedent of His If Yes, specify Cubar	n, Mexican, Puerto F	ecity Yes or No- Rican, etc )	White, etc. Whi	rican Indian, Black,
ours aftu atural" xamine	g S	15. Decedent's Education (Specify only highest grade comp	oleted) 16a. Dece	edent's Usual Dccupa ig most of working life	tion (Give kind of we		b. Kind of Business	Industry
36 in 72 ho han "n dical Ex	Completed	Elementary/Secondary (0-12) College (1-4 or 5-10)	+)	struction			Construct	ion Company
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	ᆰ	17. Father's Name (First, Middle, Last)			18.Mother's Name			
1215 d be fil- fental F narked	8	Anthony J. Torre  19a. Informant's Name/Relationship (Type, Print )	19b. M	ailing Address (Stree	Gina et and Number or R		Oung er, City or Town, Stat	e, Zip Code)
MD 2 id 2 shoul thth and M m 27 is m aumatic	٩	Anthony J. Torre (Father)	29.	51 Almondb	ury Drive	. Pasade	ena, Maryl	and 21122
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" injury or other traunnatic event, the Medical Examine		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from Star  4 Donation 5 Other Specify:	. crematory of	sposition (Name of ce or other place) Crematory			20c.Location-City of Baltimore,	Maryland
Baltin permit. P Departme Importar injury or	1	21. Signature of Fune al Service Licenses	14	22. Name and Addres	s of Facility Lyniak Fu	neral Ho	ome P.A.	. 01100
Physician	-	23a. Part I. Enter the disease, or complications that caused failure. List only one cause on each line.	the death. Do not en		, such as cardiac of	respiratory arres	la Mary La t, shock, or heart	Approximate Interval Between Onset and Death
aminer	ĺ	Immediate Cause (Final disease or condition resulting in death)  a. COMPTICATIO		otic (morphin	ie) mtoxica	ILIOII		
	-	Sequentially list conditions, If any, reading to immediate  b.  Due to for as a source	KNAROL VIII					
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated						
uted 1d ransit	Exa	events resulting in death) Last Due to (or as a conse						
O, e be executed ysician and burial - transit	edical	X UNPENDED AMENDED #23a,27,28	8a-f. perME	.g869.7/13/0	O7 TT		23d. Date of deliv	
8760 ificate l		IF FEMALE: 23c. If yes, outcon 23b. Was decedent pregnant in the		Fetal death 3	Ectopic pregna	ancy	Month	Day Year
cords, P.O. Box 6876( law requires that the death certificate has been signed by the attending phy 2. should be detached for use as the b.	Physician/M	4 Ver 0 No 0 Hoknown	time of death 5	Other (Specify)				
). BC the dea	Phy		h but not resulting in	the underlying cause	e given in Part I.	1		to the cause of death?
P.O.	d by							robably 4 Unknown
Division of Vital Records, tall or attending Physician: The law requirers after death. After this certificate has been sitted in by the funeral director, page 2 should be the funeral director.	Completed					24a. Was a autops perform	y prior	autopsy findings available to completion of cause of ?
RecC The lav cate ha	omo:					1 <b>✓</b> Yes 2		
ision of Vital Rec Attending Physician: The redeath. After this certificate by the funeral director, page	Be	25. Was case referred to medical examiner?  Hospital: 1  Inpatie	ent 2 EP/Outr	26.Pla	Other Nursi		Residence 6 0	her:
of Vi Physi er this	2	27 Manner of Death 28a. Date of Inju	ury 28b. Tin		njury at Work?		ow injury occurred	
OD C ending ath. or: Af	tion	1 Natural 5 Pending 6/27/200		10:30 pm 1	Yes 2 X No	unk		
Visior or Attene fifter death Director:	Certification:	3 Suicide 6 X Could not be 28e. Place of Ir	njury - At home, farm	n, street, factory, office	e building, etc.	or Town, St	ate)	Rural Route Number, City
E 8 E E		20a Certifier	residence ny knowledge, death	occurred at the time,	, date and place, an	d due to the cause	e(s) and manner as	Or. Pasadena. M. stated.
To the Hos within 24 h To the Fun completely	Medical	one) 2 Medical Examiner: Dn the basis of examiner and manner stated	mination and/or inve		ense number	at the time, date a	29d. Date signed	
	Ž	29b. Signature and title of certifier  Jorbe Yeaf Ma	_0		C.M.E.		July 1, 2007	
		30. Name and address of person who completed cause of Tasha Greenberg MD. Assistant Medic	death (Item 23a)	111 Penn Stree	et, Baltimore, M	— — ID 21201		
	tate	27 Ponietr	ar's Signature	Court o				
Regis			J. D. A.					
DHMH 17 Rev 1/2	2001	•	ORIG	GINAL				

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician 2007 Orlena Tipton July 5:00 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 110 Fourth Ave. Baltimore Lansdowne If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 □ M 2 🛛 F Director 212-18-1789 Feb. 1, 1922 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location or 28a-f show e notifled at 10d. Inside City Limits 10b. County 1 X Yes 2 ☐ No Completed by Funeral Director MD Baltimore Lansdowne 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with ırat", or items 23a or Examiner must be r 110 Fourth Avenue USA 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 ₩idowed 4 Divorced "natural", White permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ٩ Arlington G. Nield <u>Ora R. (Pittman) Nield</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maryland 21227 <u>John Winters</u> <u>110 Fourth Avenue Lansdowne,</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State Cumberland, Maryland □Donation 5 □ Other (Specify)

5 bn that funeral Service License Sunset Memorial Park

22. Name and Address of Facility
Ambrose Funeral Home, Inc. Funeral Service License 1328 Sulphur Spring Rd. Arbutus, MD the mode of dying, such as cardiac or respiratory arrest, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death exaces bation of Immediate Cause (Final cute week Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Due to (or as a consequence of) l any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed burial-transi resulting in death) Last Due to (or as a consequence of) physician Be Completed by Physician/Medical the use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 9☐Unknown Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an performi 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Dea 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral

> State Registrar

E Pada Neil 31. Date filed (Month, Day, Year)

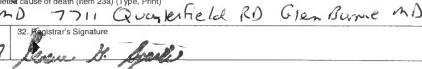
29b. Signature and title of certifier

determined

3 Suicide

29a. Certifier

4 Homicide



7711

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Tecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

1)0033296

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

107

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Depedent's Name (First, Middle, Last) 2 Date of Death **Physician** Thempson /Medical or Location of Death County of Death 4a. Facility Name (If not institution, give street and number) Examiner Klaspita Altimore 6. Sex If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday **Funeral** 1 I M 2D Director 10c. City, Town or Location 10d. Inside City Limits ortant: If Item 27 Is marked other than "neturel", or items 23a or 28a-f show Injury or other treumatic event, the Medical Exeminer must be notified at 1 Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? USD Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) -College (1-4or 5+) permit. Pages 1 and 2 should be filed.
Department of Health and Mental Hygic
Important: If Item 27 Is marked other,
any Injury or other treumatic anout. Be ( ပ 19h Mailing Address (Stree Burial 2 Cremation 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) P.O. Box 68760, 2 use as the burial-tran Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Dav 5 Other (specify) cate has been signed by the a page 2 should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. 2 1 Yes 2 No 3 Probably 4 Onknown Completed Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No this certificate has autopsy perform Division or Vital funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 ER/Outpatient 3 OA 2 1 Inpatient 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation (Month, Day Year) death. 1 Tyes 2 🗆 No 2 ☐ Accident within 24 hours after death To the Funeral Director: 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Dav. Year)

Registrar

DHMH 17 Rev 1/2001

State

00

31. Date filed (Month, Day,

101

5

and address of person who completed cause of death (Item 23a) (Type, Print)

3. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1- State of Marylar State of Marylar		artment of Health a rtificate of Death		ıl Hygiei Reg.	- 71111	7 21609
	Physicia	an	Decedent's Name (First, Middle, Last)			2. Dat	e of Death	Day Year	3. Time of Death
	/Medic	ai	DUTT TIPIRNENI			0	7 <	51 200	1 1 2 1 3
)	Examin	er	4a. Facility Name (If not institution, give street and number)	AL.	4b. City, Town, or Location			4c. County of Dea	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs.	last birthday)	If Under 1 Year If Under Months Days Hours	24 Hrs. 8. Date	e of Birth onth, Day, Ye		rthplace (State or Foreign ountry)
ď	Director		215-39-3508 NOM 2 F 70	Yrs.	World's Days Hours	Oct	17, 1	936	India
	land ow		Usual Residence of Decedent  10a. State 10b. County 10c. Cit	ty, Town or Lo	cation				10d. Inside City Limits
	Mary a-f sh	tor	Maryland Montgomery		Rockville				1 X Yes 2 □ No
	or 28	Directo	10e. Street and Number		10f. Zip Code	_	10g.	Citizen of What C	ountry?
	ath w s 23a nust b		227 Congressional Lane		20852			United S	
	be filed within 72 hours after death with the Maryland ital Hygiene. In a context than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral	11. Marital Status  1 □ Never Married 2 ▼ Married  12. Was Decedent Ever in U Armed Forces?  1 □ Yes 2▼ No	J.S.   13. \	Was Decedent of Hispanic Or If Yes, specify Cuban, Mexica	rigin? (Specify Ye ın, Puerto Rican, e	s or No- etc.)	14. Race - Am Black, Wh	
Maryland 21215-0036	urs af	þ	3 ☐ Widowed 4 ☐ Divorced Year or Dates:		1 ☐ Yes 🌠 No Specify:			Specify: Asi	an-Indian
2	72 ho 'natur dical	Completed	15. Decedent's Education (Specify only highest grade completed)	i (Give	dent's Usual Occupation kind of work done during mos	st of working	16b	. Kind of Business	
121	within ane.  than "	du	Elementary/Secondary (0-12) College (1-4or 5+) 5+	life. L	DO NOT use retired)	3		NC Store	
9	filed w Hygier other th	ပ္ပ	17. Father's Name (First, Middle, Last)		nager 18. Mothe	er's Name (First,			<u>:</u>
lan/	should be filed and Mental Hygi s marked other umatic event, t	To Be	Dasaradha Ramaiah Tipirneni		Manol	haramma	Pinna	maneni	
ary	3 E S E		19a. Informant's Name/Relationship (Type. Print)	19b. Mailin	ng Address (Street and Numb				,
<u>`</u>	s 1 and 2 of Health item 27 other tra	ч	Sarojini Tipirneni/ wife		Congressional				land 20852
Baltimore,	State				sition (Name of matory or other place)	Date	1	Location - City o	
	permit. Page Department ( Important: If any Injury or once.		4 □ Donation 5 □ Other (Specify) Wess 21. Signature of Funeral Service Licenses		del Crematory			lenton, N	
Ba	Dep Jany any any any		Quanta R Thomas	14	Name and Address of Facili Onaldson Fune 11 Annapolis	ral Home Road Od	& Cre	ematory, Marylar	P.A. nd 21113
	95) 900		23a. Part 1. Enter the disease, or complications that caused the deat shock, or heart failure. List only one cause on each line.	th. Do not ent	er the mode of dying, such as	cardiac or respir	atory arrest,		Approximate Interval Between
7	Physician		Immediate Cause (Final disease or condition resulting in death)	any	Hovery	Dis	car	4	Onset and Death
\$	/Medical Examiner		Due to (or as a gonseo	quenco of):	hoch				
h		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	quence of):	,				
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60,	icate be executed physician and s the burial-transit	Ě	Due to (or as a consequence of the consequence of t	ence of):					
68760,	ificate be executed physician and as the burial-transit	edical	d					_	
Box	death certifi e attending d for use as	W/u	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Feta		Ectopic pregnancy			23d. Date of de	elivery
	0 0	Physician/M	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of c		Other (specify)			Month	Day Year
о. О	The law requires that the de the has been signed by the a sage 2 should be detached to		9 ☐ Unknown   9☐ Unknown  Part II. Other significant conditions contributing to death but not res	sulting in the ur	oderlying cause given in Part I	23	a Did tohaco	o use contribute	to the cause of death?
Vital Records,	uires t	d by			, and the same of the same of the same		1 ☐ Yes		robably 4 □Unknown
Ö	w requires been significant si	lete				246	a. Was an	24b. Were a	utopsy findings available
Ä	The lay	Completed					autopsy performed	? prior to death?	completion of cause of
<u>I</u>	slcian; The la certificate ha irector, page 2	Bec	25. Was case referred to medical examiner?		26. Place	e of Death (Check		1010	5 2131140
0	hysic this ce al dire	P	1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ☐	ER/Outpatien				6 □Other (Sp.	ecify)
0	ding h. After funer	tion:	27. Manner of D <sup>*</sup> ath  1 Natural 5 Pending (Month, Day Year)  2 Accident investigation	28b. Time of Injury	28c. Injury at Work?  M 1 □ Yes 2 □		scribe how ir	njury occurred	
DIVISION	Atten r deat ector: by the	ifica	3 Suicide 6 Could not be determined 28e. Place of injury - At he			28f. Loc	ation (Street	and Number or F	lural Route Number,
בֿ	tal or rs afte ral Dir led in	Certification:	building, etc. (Special	ry) 		City	or Town, St	rate)	
		edical	29a. Certifier  (Check only one)  2 Medical Examiner: On the basis of examine and manner stated.	owledge, death ation and/or in	n occurred at the time, date ar vestigation, in my opinion, dea	nd place, and due ath occurred at th	to the cause e time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)
	To the within to the comple	Mec	29b. Signature and title of certifier		29c. License number		29d.	Date signed (Mor	th, Day, Year)
)			Salu Hus	paper.	5848	4	11	July 07	Z
	10		30. Name and address of person who completed cause of death (Item		· ·	M1	1 000	(	
	Sta	e l	Salim Aziz, M.D. 7600 Carroll A 31. Date filed (Month, Day, Year)  Registrar's Sign	ature	Takoma Park,	Marylan	a 2091	1.2	
	Registra		31. Date filed (Month, Day, Year)  Registrar's Sign	F. Agos	age.				

Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** WILLIAM CECIL UNZICKER July 1, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Doctor's Community Hospital Lanham Prince George's If Under 24 Hrs. Hours Min. 5. Social Security Number If Under 1 Year 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 X M 2 □ F Director 577-44-6770 71 07-22-1935 Washington, DC Usual Residence of Decedent r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No Director Maryland | Prince George's Riverdale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 7 4911 Queensbury Road 20737 U.S.A. death v Funeral Item 27 is marked other than "natural", or Items other traumatic event, the Medical Examiner man 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 M Yes 2 □ No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify Specify: White Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) 10 Supply Officer District Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Kenneth Brown Unzicker ပ Helen Branz 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a Joyce M. Alderson - Sister 4912 Riverdale Road, Riverdale, Maryland 20737 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of F Important: if ite any injury or other 1 X Burial 2 ☐ Cremation 3 X Removal from State 4 □ Donation 5 □ Other (Specify) Mount Hope Cemetery 07-09-2007 Sibley, IL 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 4739 Baltimore Ave. Gasch's Funeral Home, P.A. Hyattsville, MD 20781 aux UM Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and the burial-transi Due to (or as a consequence of): P.O. Box 68760. Physician/Medical as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No for Month 4☐Pregnant at time of death 5 ☐ Other (specify) the 9 ☐ Unknown ate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. þ 1 🗹 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy perform 1□ Yes 2 No Physician: 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient ို 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 27. Manny Death ne Hospital or Attending Pr n 24 hours after death. he Funeral Director; After the eletely filled in by the funera 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

within 24 the

> State Registrar

Medical

31. Date filed (Month, Day, Year) 0 5 2007

Madhu K. Mohan, MD

29b. Signature and title of certifier

29a. Certifier

(Check only one)

6502 Kenilworth Avenue, Suite 100, Riverdale, MD 20737 32 egistrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

07-03-07

DHMH 17 Rev 1/2001

Registrar

State

BALTIMORE

21287

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HUI-CHOU

0 5 2007

HELEN

31. Date filed (Month, Day, Year)

600 N. WULFE STREET

32. Registrar's Signature

Registrar

State

BAHRAM PISHDAD, MD

31 Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

1328 SOUTHERN AVENUE, SE

WASHINGTON, DC

Registrar DHMH 17 Rev 1/2001

State

29b. Signature ar

30. Name and address of person who con

JUL

<sup>Year)</sup> 2007

31. Date filed (Month, Day,

pleted cause of death (I)en 23a) (Tope, Print

Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

7007

JULY 5

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Year Month RGINIA 2 ( , 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1 ■ M 2 X F 80 Virginia 218-22-9954 July 16, 1926 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Pasadena Marvland Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 511 Edgewater Road 21122 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14 Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify. Specify 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) N.S.A. Analyst 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Myrtle Hurt Purdue Price 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peggy L. Rayford (Daughter) 511 Edgewater Road Pasadena, Maryland 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Glen Haven Mem. Pk. 07/02/07 Glen Burnie, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 Mins 23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 60 neumon Due to (or as a consequence of) Que Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 □ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a. Was an autopsy perform 2 0 No 25. Was case referred to medical examiner?

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r 28a-f show notified at

"natural", or Items 23a or

event, the Medical

If Item 27 or other t

permit. Pages 1 Department of H Important: If Itel any Injury or ott

s 1 and 2 should be filed with Health and Mental Hygier teem 27 Is marked other th

Director

Completed by Funeral

Be

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Examiner

Physician/Medical

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Completed

Be

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Certification:

Medical

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

that the death certificate be executed and burial-trar physician the as attending p for use as þ signed t has page 2 s certificate To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director; After this certifica

Records, P.O.

Division or Vital

IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🖟 No 9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

28a. Date of Injury (Month, Day Year)

and manner stated

26. Place of Death (Check only one, Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 npatient 2 ER/Outpatient 3 DOA

1 ☐ Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28d. Describe how injury occurred 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

(Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of cartifier,

4 ☐ Homicide

29a. Certifier

29c. License number

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type A M

BUSE HIGH WAY ANNAPOUS MONGO,

State Registrar

completely filled in by the

32 Registrar's Signature 31. Date filed (Month, Day, Year) 0 5

State Registrar DHMH 17 Rev 1/2001 20, crossroad

32. Redistrar's Signature

Kawala

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year Physician 01,2007 Maria Zito TULY /Medical 4a. Facility Name (If not institution, give street and number)
Levindale Hebrew Geriatric
Center and hospice
5. Social Security Number 6. Sex 7. Ag 4b. City. Town, or Location of Death 4c. County of Death Examiner BALTIMORE If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□ M & R 77 Yrs. Director 218-42-2424 1/28/1930 Tusa, Italy Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show Item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1213 Newfield Road Italy
14. Race - American Indian, Funeral 21207 Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. ant: If Item 27 Is marked other than "natural", or Items 23s 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes A No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No White þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Seamstress Haas Tailor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ္ Paolo Tasca Annunziata Tudisca 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1213 Newfield Road Baltimore, Maryland 21207 Giuseppe Zito (husband) 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Valley
Memorial Gardens July 6, 2007 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages of Pepartment of Pepartment of Pepartment: If Ite any injury or of once. 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens Peaceful Alternatives Funeral & cremation Ctr., P.A ۅۜ 2325 York Road Timonium, Maryland 21093 sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, tree. List only one pulse on each line. 23a. Part . Enter the dis shock, for heart shill Imme ate Cause (Final Approximate Interval Between Onset and Death CORONARY ARTERY **Physician** DISCHSE disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consquence of Examine Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 9□Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? FIBRILLHTLON 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed HYPOTHYRDIA 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performe RISPIRATORY FAILURE After this certificate 1 Yes 2 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation (Month, Day Year) Injury 1X Natural To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu 1 ∏Yes 2 ∏No death. 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

4

31. Date filed (Month, Day, Year)

GIZAW WOLDEHINOT

2434 WEST BELUEDERE AUE, BALTIMORE MD 21237
32. Begistrar's Signature

thistw H. WUNDETHWET, MD

2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 20063327

07/02/2007

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 28 2007 June 5:00A Hamilton Arbaugh John /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Union Bridge Carroll 138 Pipe Creek Road If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Country) 1**⊠** M 2□ F 1, 1932 Pennsylvania 217-36-3847 Mar. Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 28a-f show ns 23a or 28a-f shov must be notified at 1 ☐ Yes 2 No Director Union Bridge Maryland Carroll permit. Pages 1 and 2 should be filed within 72 hours after death with the N Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f any injury or other traumatic event, the Medical Examinar months. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21791 U.S.A. 138 Pipe Creek Rd. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 Never Married 2 M Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: δ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) farmer dairy 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Helen Strevig Atley Arbaugh 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Union Bridge, MD 21791 138 Pipe Creek Rd. Doris Arbaugh/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Pipe Creek Cemetery ∮6/30/2007 | nr. Linwood, MD 22. Name and Address of Facility Hartzler Funeral Home 21. Signature of Funeral Service Licenses athania ( New Windsor, MD 21776 310 Church St. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final o month Cerebrosaswiz **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 10 year two Sequentially list conditions, if any, reading to introduce cause. Enter Underlying Cause (Disease or injury Due to for an exponentience of Examiner Hospital or Attending Physician: The law requires that the death cerificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, ttendir-g physician or use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No Division or Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 1 | Yes 2 - 1√0 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this after death.

I Director: After this d in by the funeral d 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide e Funeral I 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 6/29/07 D 43643 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21787 13 A. TATE m.D. vingo 32. Egistrar's Signature 31. Date filed (Month, Day, Year) State

Registrar

2007

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## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Mary		artment of He <i>tificate of D</i>			iene <sub>eg. No.</sub> 20	07	21618
	Physici		1. Decedent's Name (First, Middle, Last) TEP-72.4	BEN	SON			2. Date of Dear Month	Day	Year O'7	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, give s	treet and number)	20	4b. City, Town, or L	ocation of Death		4c. County	of Death	4
			5. Social Security Number 6. Sex	morrel (to	yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		O Birtho	Jana (State or Foreign
b	Funeral Director			M 2DE	50 Yrs.	Months Days	Hours Min.	08/03,	Year)	Minn	lace (State or Foreign try) esota
	iand ow		Usual Residence of Decedent  10a. State 10b. County	10	c. City, Town or Lo	cation				1	Od. Inside City Limits
	a-feh	ctor	WV Tucker		Davis						1 XYes 2 ☐ No
	or 28	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of	What Cour	try?
	eath y		5th Street	2. Was Decedent Eve	rin IIS 13 V	26260	panic Origin? (Spe	city Ves or No-	USA 14 Bac	e - Americ	an Indian
36	s within 72 hours after death with the Maryland liene. r than "natural", or iteme 23a or 28a-1 ehow the Medical Examinar must be notified at	y Funeral	1 ☐ Never Married 2 Married	Armed Forces? 1 XYes 2 □ No		Was Decedent of Hisp f Yes, specify Cuban, I □ Yes 2¶ No	, Mexican, Puerto F	Rican, etc.)	Bla	ck, White,	etc.
21215-0036	2 hours	ted by	3 Widowed 4 Divorced	Year or Dates: 6	16a. Deced	dent's Usual Occupati	ion		16b. Kind of B		
215	within 72 iene. r than "n	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	kind of work done du DO NOT use retired)		ng	_		
121	4 5 4 E		12 17. Father's Name (First, Middle, Last)		MIII	tary/ US	Army  18. Mother's Name	(First Middle )	Gover		t
Maryland	a ia B	To Be	Jack Leigh B	enson				Jane (		,	
lary	and and ie m		19a. Informant's Name/Relationship (Ty)	oe, Print)		g Address (Street an					10.1
	s 1 and 3 f Health item 27 othar tr		Robert Benson  20a. Method of Disposition	12	7455	Merryma	aker Way		Ridge,		
Baltimore,	Peges nent of ant; if if ary or c		1 🖾 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	onioval nom State	cemetery, crem Arlingto	sition (Name of natory or other place) n Nat'l				•	on, D.C.
Balt	permit. Peg Department important; i eny injury o		21. Signature of Foneral Service License	nkle	P P	Name and Address 1nkle Fu .O. Box	ineral H	Home.	[nc.		
			23a. Part1. Enter the disease, or compli- shock, or heart failure. List only or	cations that caused the e cause on each line.	death. Do not ente	er the mode of dying,	such as cardiac or	r respiratory arri	est,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a co	Myo	cardia	O In	tave	tron		Thour
	Examiner		Sequentially list conditions	Autor	-10 sch	eratic (	Colonar	Vac	cular		
7	ted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	onsequence of):			J. Di	gay		
v O	ificate be executed g physicien and as the burial-transit	Exar	that initiated events cresulting in death) Last	Due to (or as a co	onsequence of):						
68760,	cate be physici the bu	edicai									
Вох 6		n/Me	IF FEMALE: 23b. Was decedent pregnant 2	3c. If yes, outcome of p		le			23d. Da	te of delive	ry
o.	at the deat by the atte	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1☐Live birth 2☐ 4☐Pregnant at time 9☐ Unknown		Ectopic pregnancy Other (specify)			Мо	nth	Day Year
rds, P	gned ge de	by	Part II. Other significant conditions con	tributing to death but no	ot resulting in the ur	nderlying cause given	in Part I.		oacco use cont es 2 □ No	ribute to th	e cause of death?
of Vital Records,	e law requin hes been si je 2 should l	Completed						24a. Was a autops			osy findings available npletion of cause of
a R								perform	ned?	death?	2 No
Z:	Physicien; this certificaral director, p	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	ospital:	2 X R/Outpatien	Cthor	26. Place of Death 4 ☐ Nursing Horr			os (Coss)	
	ding Phys h. After this funeral di		27. Manner of Death  1  Natural 5  Pending	28a. Date of Injury (Month, Day Ye	28b. Time of	28c. Injury a Work?		8d. Describe ho			9
Division	Attending r death. ector; After by the fune	cath	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury		M 1□Ye	es 2 No	18f Location (St	reat and Numb	or or Pum	l Route Number,
<u>≥</u>	tal or Atten is efter deat et Director; ed in by the	Certification:	4 Homicide determined	building, etc. (5	Specify)	set, factory, office		City or Town		er or Hura	n noble whiliper,
	To the Hospital or Atten within 24 hours efter deat To the Funerel Director; completely filled in by the	ledical	29a. Certifier (Check only one) 1 Certifying Phys	ician: To the best of mer: On the basis of exa and manner stated	amination and/or inv	occurred at the time restigation, in my opin	, date and place, a nion, death occurre	nd due to the ca	ause(s) and ma ate and place,	anner as st and due to	ated. the cause(s)
	To the within 2 To the complet	Ň	29b. Signature and title of certifier	m	\0	29c. License r		2	9d. Date signe	d (Month,	Day, Year)
			Vaul Danis	Miller &	(Hom 22=) (Time )	1721	6177		9 (	8/0	7
	10		Paul Daviel Mi	mpleted cause of death	7 Wolt	Teres	Dr.C	aklar	X Mi	)2	1550
	Sta Registr		31. Date liled (Month, Day, Year)  JUL 0 5 2007	3. Registrar's	de Ange	les.			1		

07-04852 Da

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Dale Brinley		State of Maryland / Department of Healt - For State Certificate of Death			Reg. No. 201	7 2 6 1
Physician	/	egistrar I. Decedent's Name (First, Middle,Last)		Date of Dea     Month	ath Day Year	3. Time of Death 0900 hrs
Medical Examine		Dale W. Brinley  4a. Facility Name (if not institution, give street and number)  4b. City, T	Town, or Location of Dea	June 26,	4c. County of Dea	
Ŕ	H	University Hospital Baltim				
Funeral	Ţ	276-32-6681 Months		irs. 8. Date of B	irth(MM/DD/YYYY) 9. B Fore	ian
Director		419 88 4905 1 X M 2 F 71 Yrs.		May	2,1936 C	Ohio
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
<b>*</b>	5	Ohio Richland Lexington		7.47		1X Yes 2 No
the Maryland nor 28a-f sh		10e. Street and Number 10f. Zip			10g. Citizen of What Co	untry?
with the Maryland s 23a or 28a-f show e.notified at once.		16 Avon Drive 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decede	44904 ent of Hispanic Origin? (	Specify Yes or N	U.S.A.	erican Indian, Black,
leath w	Funeral		fy Cuban, Mexican, Puer		White, etc.	
s after c		3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2	No specify:		Specify: Wh	
hours "natur Exam	<u>g</u> -	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)	Occupation (Give kind or rking life. DO NOT use r		16b. Kind of Business	s/Industry
5-0036 ed within 72 hour lygiene. other than "nature the Medical Example Completed	n De	12 Baker			Bakery	
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica		17. Father's Name (First, Middle, Last)			, Maiden Surname)	
2121 2121 Muld be f Mental markee c event	o٢	Jay Brinley  19a Informant's Name/Relationship (Type, Print )  19b. Mailing Address	Soph:	ia Sche or Rural Route Nu	elk umber, City or Town, Sta	te, Zip Code)
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiera Handland Mental Hygiera is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Eimeral Director	-				Ohio 449(	
re, re land s land f Healt f Healt f fiem f ritem		20a. Method of Disposition  20b. Place of Disposition (Nar crematory or other place)  Removal from State	ne of cemetery,	Date	20c. Location - City	or Town, State
Baltimore, permit. Pages I ai Department of He Important: If ite		4 Donation 5 Other Specify: Mansfield Me	em.Park 6	/30/07	Mansfiel	d,Ohio
Balt permit Depart Impor injury		21. Signature of Funeral Service Licensee 22. Name and	Address of Facility  Ma	arzullo	Funeral timore, Ma	Chapel P.A
Physician	+	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode $\mathfrak c$	ariora Ro of dying, such as cardia	c or respiratory a	rrest, shock, or heart	Approximate Interval Between Onset and
Medical (		failure. List only one cause on each line.  Immediate Cause (Final disease a. Hypertensive Atherosclerotic Cardiovascu	ılar Disease			Death
kaminer		or condition resulting in death)  Due to (or as a consequence of):				
	[텔	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
ted (A)	<u>E</u>	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):				+
0, % s be executed sician and ourial - transit	<u></u>	d				
0, c be execute e be execute burial - tran	edical	UNPENDED X AMENDED TIFM/5, perFH, C869, 7/6/	07,WS		Lood Date of delice	
Box 68760, he death certificate be expended the attending physician hed for use as the burial buries in the burial buries in the buries as the		IF FEMALE:  33b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death	3 Ectopic preg	gnancy	Month	Day Year
Box 6 e death cer the attend ed for use	SICE	4 Pregnant at time of death 5 Other (Spe 1 Yes 2 No 9 Unknown g Unknown	cify)			
s, P.O. Be inters that the designed by the standard of the detached for the standard for th		Part II. Other significant conditions contributing to death but not resulting in the underlying	g cause given in Part I.	23e. Did	tobacco use contribute	to the cause of death?
ires that the signed by be detack	g p	Diabetes Mellitus			es 2 No 3 P	
cords,	plete					autopsy findings available ocompletion of cause of
n of Vital Records, ling Physician: The law requir After this certificate has been s functal director, page 2 should 1	Completed			1 Yes		Yes 2 No
Vital Reconsisting the continuate this certificate of director, page	Be	examiner? Hospital: 4 Innation: 3 ED/Outnation: 3	26.Place of Death (Che	rsing Home 5	Residence 6 Ott	ner:
of V ing Phys After thi Tuneral d	읽	27. Manner of Death 28a. Date of Injury 28b. Time of Injury	28c. Injury at Work?		e how injury occurred	
ion trendir teath. tor: A	턃	Natural 5 Pending Accident Investigation	1 Yes 2 No			
Division pital or Attendir ours after death.	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory	, office building, etc.	28f. Location or Town		Rural Route Number, City
		4 Homicide  29a. Certifier A Contificing Physicians To the heat of my knowledge, death accurred at the	e time, date and place, a	and due to the ca	use(s) and manner as s	ated.
To the Hos within 24 h Completely	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in m and manner stated.	y opinion, death occurre	ed at the time, da	te and place, and due to	the cause(s)
E 3 F 3	≝¦		c. License number		29d. Date signed (M	Nonth, Day, Year)
		fotultionia tollet us	O.C.M.E.		June 26, 2007	
6		<ol> <li>Name and address of person who completed cause of death (Item 23a)</li> <li>Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 P</li> </ol>	enn Street, Baltim	nore, MD 212	201	
Stat		31. Date filed (Month, Day, Year) 32. Segistrar's Signature				
Registra	ar	1111 0 5 2007 Regue D. Specker				

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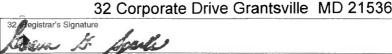
#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 30, 2007 0730 Blake JUNE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Rawlings Allegany 18510 McMullen Highway If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex Age (In yrs. last birthday 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🔀 F MD Dec 4, 1928 78 Director 233-44-5182 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County : If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No MD Allegany Rawlings Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21557 USA 18510 McMullen Highway Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 □ Yes 2 □ Xno Baltimore, Maryland 21215-0036 ρ Specify: 3 X Widowed 4 □ Divorced white Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Celanese Corp. Secretary 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be 2 should be f Irene (Miller) Llewellyn Clarence U. Llewellyn, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is n any injury or other traun MD 21557 18510 McMullen Highway Rawlings sister Anna Llewellyn 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ Removal from State 7/2/2007 Frostburg Memorial Park MD Frostburg 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Scarpelli Funeral Home, PA 21. Signature of Enn val Service Lines ee 108 Virginia Avenue: Cumberland, MD 21502 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition **Physician** Muscular Dystrophy 10 years resulting in death) /Medical Due to (or as a consequence of) Examiner 10 years Chronic Obstructive Pulmonary Disease Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner be executed sician and burial-trans Due to (or as a consequence of) P.O. Box 68760, as the burial Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, \$ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an certificate 1□ Yes 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient this P 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No spital or Attendi ours after death. neral Director: A filled in by the fu death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours aff To the Funeral D 29a. Certifier 🖎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

Registrar

Habib Chotani M.D. 31. Date filed (Month, Day, Year) State

29b. Signature and title of certifier

JUL 05



Protaul

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



29c. License number

D0058853

29d. Date signed (Month, Day, Year)

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene

			For State AMENDHO SOUTH	State of Ma	•		ırımeni d <i>tificate</i>			-	_		8	
		jě.	State     Registra MEND#8, perFH  1. Decedent's Name (First, Middle, L		<u> </u>	Oei	incate	01 0	Cattr	2. Date of De	ath	007	3. Time of De	éth
e,	Physicia /Medic		Charlena Charlena	н.	Bryant					Month June	Day 18	Year 2007	7:00	a <sub>M</sub>
	Examin	125	4a. Facility Name (If not institution, g.				4b. City, To		ocation of Death		4c. C	ounty of Death		
	\$45 ·		Arden Court Nursing		/Im rum Inat his	th dout)	If Under 1		er Spring	8. Date of Bir	th.	Montgo		Foreign
	Funeral Director		338-18-0918	Sex 7. Age 1 □ M 2 ☑ F	(In yrs. last bir 96	Yrs.				August 1		A 7 - 1	lace (State or F try) ama	oreign
	and w	1	Usual Residence of Decedent  10a. State 10b. County		10c. City, Tow	n or Lo	cation					1	0d. Inside City I	Limits
	f sho	ō	Maryland Freder	ick				New	Market				1 ☐ Yes 2	<b>⊠</b> No
	the 1 28a- notifi	Directo	10e. Street and Number				10f. Zip Co	ode			10g. Citize	n of What Cour	itry?	
	3a or		10590 Edwardian La	ne				217	74			U.S	.A.	
	ms 2	Funeral	11. Marital Status	12. Was Decedent 8 Armed Forces?	ver in U.S.	13. V	Vas Deceder	nt of Hisp	panic Origin? (Spe Mexican, Puerto	ecify Yes or No	)- 14	I. Race - Americ Black, White,		
21215-0036	be filed within 72 hours after death with the Maryland its Hygliene. Additional other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced		lo		1 □ Yes 2 ∑		Specify:	ritoari, cio.j		Specify:	Black	
Õ	72 ho natur lical f	Completed	15. Decedent's (Specify only highest of	Education	16a	Deced (Give	lent's Usual (	Occupati	ion rina most of work	ing	16b. Kind	f of Business/Inc	dustry	
21	within 7 iene. than "r	nple	Elementary/Secondary (0-12)	College (1-4or 5	+)				ring most of work		0-1	1 C		
21	e filed will Hygier other the	Ö		5+			Educatio		ministrato 8. Mother's Name			nool Syst		
n a	be fill Hall Hall Hall Hall Hall Hall Hall H	Be	17. Father's Name (First, Middle, La					'		•	, ivialueri o	umamej		
ĭŞ.	should be nd Mental marked matic ev	2	Charles Howa 19a. Informant's Name/Relationship		194	Mailin	na Address (S	Street an	d Number or Run	Howard	ner City or	Town State Zir	Code)	
Maryland	d 2 sl th an 7 Is r traur	Πi	Annie B. Belton -				•		ane, New M				,	
نې	1 an Heal Fem 2		20a. Method of Disposition	Daughter	20b. Place o					Date		ation - City or To	own, State	
altimore,	ages ent of t: If ii		1 ☐ Burial 2 ☑ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe				natory or ound In Crema			/2007	Brentw	ood, Mary	land	
#	nit. Fartmoortan		21. Signature of Funeral Service Lic		10.72	22	2. Name and	Address	of Facility			, , , , , , , , ,		
ñ	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any Injury or other traumatic ev	0 /	1 Domany	J. Tarca	بالسب	4 I	ines-Ri 1800 Nev	naldi w Ham	Funeral H pshire Ave	nue, Inc	ver Sp	ring, Mar	yland 209	04
			23a. Part1. Enter the disease, or co	mplications that caused ly one cause on each lin	the death. Do	not ent	er the mode	of dying,	such as cardiac	or respiratory a	arrest,		Approximate Interval Between	
1	Physician	a y	Immediate See (Final disease or condition		lmer's Di								Onset and De	atn
	/Medical		resulting in death)	Due to (or as	a consequence	of):		-						
	Examiner		Sequentially list conditions.	D	cension									
	pi ji	Examine	Sequentially list conditions, if any, leading to immediate cause. Linter Unidentifying Cause (Disease or injury		a consequence									
	ecute and I-trans	хаш	that initiated events resulting in death) Last	U	lipidemia a consequence									
90	be ey ician buria	a E		·	nyroidism									
68760,	ficate be executed physician and s the burial-transit	edical		d	.,									
Box	death certi e attending ed for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal deat		∃Ectopic preg ∃ Other (spec				23	3d. Date of delive Month	ery Day Ye	ar
, P.O	de ed		Part II. Other significant condition	s contributing to death b	ut not resulting i	in the u	nderlying cau	ıse giver	ı in Part I.	23e. Did	tobacco us	e contribute to t	he cause of dea	ath?
ds	quires n sign	d by								1 🗆	Yes 2□	No 3□ Prol	bably 4 ⊠Un	known
or Vital Records,	aw require s been sig s should b	Completed								24a. Was		24b. Were auto	opsy findings av	/ailable
æ	0 7 0	mo								perf	opsy ormed? 2 No	death?	mpletion of cau 2□ No	156 01
ta	sician: The certificate rector, pag	BeC	25. Was case referred to medical	1					26. Place of Deat					
>	<u>≅</u> . <u>≅</u>	TOE	examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ Inpatie	ent 2□ER/O	utpatier	nt 3□ DOA	Other	4 Nursing Ho	ome 5 Res	sidence 6	□Other (Speci	fy)	
0 [	ding Ph After th funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da		Time o Injury	f 280	c. Injury Work?		28d. Describe	how injury	occurred		
Sio	Attendii death. ctor: A y the fu	catic	2 Accident investigat 3 Suicide 6 Could not	h -		-	М		es 2□No				10 11 11 -1	
Division		Certification:	4 Homicide determine		ury - At home, f c. <i>(Specify)</i>	arm, str	reet, factory,	опісе		City or To	(Street and own, State)	Number or Run	ai Houte Numbi	er,
	To the Hospital or / within 24 hours after To the Funeral Dire completely filled in b	Medical (	29a. Certifier 1 ☐ Certifying (Check only one)	Physician: To the best aminer: On the basis o and manner sta	f examination a	je, deat nd/or in	h occurred at vestigation, i	t the time in my op	e, date and place inion, death occu	, and due to the rred at the time	e cause(s) e, date and	and manner as s place, and due f	stated. to the cause(s)	
	To the within 2 To the complete	Ž	29b. Signature and title of certifier	(2)		1	29c.	License	number			signed (Month,		
			> Kuli	Vote	a	11		D202	274		June	18, 2007	'	
	12		30. Name and address of person wi						1 0005					
			Kirti Vohra, M.D.,			sethe	esda, Ma	rylar	nd 20817					
State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature														

DHMH 17 Rev 1/2001

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State	of Maryla		ertment of H		d Mental I		200	7	21622
			Registrar  1. Decedent's Name (First, Middle	. Last)			inoute of i	504111	2. Date of	Reg. No	01	-	3. Time of Death
	Physici		Wayne Cecil B						June June		3, 200		9:00a <sup>™</sup>
	/Medic Examin		4a. Facility Name (If not institution		umber)		4b. City, Town, or	Location of De			c. County of D		J.000
	LAUTHI	ر ا جود	The Annapolita	an			A	nnapoli	.s		Anne	Aru	ndel
9.7	- Funeral		5. Social Security Number	6. Sex	7. Age (In yrs	s. last birthday)	If Under 1 Year Months Days	If Under 24 H	in (Month	. Dav. Year	9.	Birthpla	ace (State or Foreign try)
14.	¿ Director	Į	552-22-9722	1 M 2 □ F	85	Yrs.	Morning Days		Mar.	29,	1922		IL
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	ne 23	Funeral	17.04 SOULI Hall	12. Was De	cedent Ever in	U.S. 13. V	Was Decedent of H f Yes, specify Cuba		(Specify Yes o	r No-	14. Race - A	Amenca	an Indian,
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ē,	f Heal		20a. Method of Disposition			Place of Dispo		T	Date	-	Location - City		wn, State
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33	Division	03 1	shock, or heart failure. List Immediate Cause (Final	only one cause on	each-line.	ERE	(2)c	EAAC	NTI	14			Interval Between Onset and Death
4	Physician /Medical		disease or condition resulting in death)	a	o (or as a conse		,,,,	IVIC	10/1	1			
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2	Sta Regist		31. Date filed (Month, Day, Year)	2007	egistrar's Sig	mature A							Mal
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death . <sup>D</sup>2007 June 16, **Physician** Opal Etheline Buchanan 7:00 A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Genesis Elder Care - Spa Creek Annapolis Anne Arundel 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 M 2 T 536-22-8357 Nebraska Dec.10,1910 96 Director Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Marel Hygiene. Important: If time Z1 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland | Anne Arundel Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3883 Cotter Drive 21037 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2√√No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Specify: White by 3√√Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sales Clerk Retail 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be f nent of Health and Mental I ant: If Item 27 is marked o Homer Huston Clara Herndon 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen E. Wilburn/daughter 3883 Cotter Drive, Edgewater, Maryland 21037 20b. Place of Disposition (Name of cemetery, crematory or other place)
Kalas Crematory 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Edgewater, Md. 6-18-07 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature of Fun 2973 Solomons Island Rd., Edgewater, Md. 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed? Yes 2 No has 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA ည 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? To the Hospital or Attending F within 24 hours after death.
To the Funeral Director: After it Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

I medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and little of dertif 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1010 2108 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 2 0 2007 Registrar

DHMH 17 Rev 1/2001

Certificate of Death

2007

12:50 PM

9. Birthplace (State or Foreign

10d. Inside City Limits

1 □ Yes 2√No

Oklahoma

**Black** 

Month

Year

Day

3 ☐ Probably 4 ☐ Unknown

State Registrar

1 - For State Registrar

14300 Gallant Fox Lane 32. Redistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JUN 2 0 2007

Dr. Rakesh Arora 31. Date filed (Month, Day, Year)

Bowie, Maryland 20715

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

			For State Registrar	State of	Marylan		artment rtificate				ental Hyg	eg. No:	07	21625
	Dhysioi	212	1. Decedent's Name (First, Middle, La	st)							2. Date of Dea Month	th Day	Year	3. Time of Death
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21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Itam 27 is marked other then "natural", or Itams 23a or 23s-f ahow other traumatic event, Itse Marical Examinational Learnaithe and Itse Assets and a second other traumatic event, Itse Marical Examinational Learnaithe and Itse Assets and Itse Marical Examination and Itse Marical Examination and Itse Marical Examinations and Itse Marical Examinations are second and Itse Marical Examinations and Itse Marical Examinations are second and Itse Marical Examinations and Itse Marical Examinations are second and Itse Marical Examinations and Itse Marical Examinations are second and Itse Marical Examinations and Itse Marical Examinations are second and Itse Marical Examinations and Itse Marical Examinations and Itse Marical Examinations are second and Itse Marical Examinations and Itse Marical Examinations are second and Itse Marical Examinations and Itse Marical Examinations and Itse Marical Examinations are second and Itse Marical Examinations and Itse Marical Examinations and Itse Marical Examinations are second and Itse Marical Examinations and Itse Marical Examinations are second and Itse Marical Examinations are second and Itse Marical Examinations and Itse Marical Examinations are second and Itse Marical Examinations and Itse Marical Examinations are second and Itse Marical Examinations and Itse Marical Examinations are second and Itse Marical Examinations and Itse Marical Examinations are second and Itse Marical Examinations and Itse Marical Examinations are second and Itse Marical Examinations and Itse Marical Examinations are second and Itse Marical Examinations are second and Itse Marical Examinations and Itse Marical Examinations are second and Itse Marical Examinations and Itse Marical Examinations are second and Itse Marical Examinations are seco	by Funeral Director	1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	Armed Ford 1 Tes 2 If Yes, Give Year or Dat	es? (XNo		If Yes, specif 1 ☐ Yes 2[		Specify:	i, Puèrto	ecify Yes or No- Rican, etc.)	BI	ack, White hify: WHI	, etc.
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Baltimore,	permit. Pages 1 and 2 Department of Health e Important: If itam 27 is any injury or other tra		21. Signature of Funeral Service Lice		00547		O W. M.				IERS FUN FROSTBU	ERAL H	OME,	P.A. 32
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	1		30. Name and address of person who	completed cause	of death (Item	23a) (Type.			- (	1		3 227		\
	10		Harrit S. Si	dhu	425	Bish	ap W	als	hRe	2 (	umb	uclan	d,M	01.21502
ľ	Sta Registr		31. Date filed (Month, Day, Year)	32 <b>A</b> e	gistrar's Signar	ture	and a							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month <sup>Day</sup> 2007 **Physician** June 17, 9:00 A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Household of Angels Assisted Living Crofton Anne Arundel If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Date of Birth (Month, Day, Year) 2/9/1952 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 1 M M 2 □ F 9. Birthplace (State or Foreign **Funeral** Washington, DC 220-50-8494 55 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b County "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 Yes 2 No Funeral Director Maryland Anne Arundel Crofton 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 should be filed within 72 hours after death with and Mental Hygiene.
Is marked other than "natural", or items 23a or? 21114 USA 939 Truro Lane 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify Completed by White 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) or other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9th Repairman Sales and Repairs 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Ly Important: If item 27 is marked oth any injury or other traumatic event once. Cyd Cyr Marie Ryall Walker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fran W. Dugan/ Sister 939 Truro Lane, Crofton, MD 21114 20a. Method of Disposition
1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 6-19-07 Kalas Crematory Edgewater, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signatur of Funeral Softic 2973 Solomons Island Road, Edgewater, Md.21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Years /Medical Due to (or a a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Did to (or as a consequence of) certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: . If yes, outcome pf pregnancy 1□Live birth 2□Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy 2 Fetal death in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 TYes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has birector, page 2 s autopsy 1□ Yes 20 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Assisted 1 ☐ Yes 2 💢 No P 1 🔲 Inpatient 2 ER/Outpatient 3 DOA After this To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Living Certification: 10 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Paul Berez MD 2225E Detense Hwx Crofton MD 21114

State Registrar

31. Date filed (Month, Day, Year)

Registrar's Signature

JUN 2 0 2007

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2019 12:15 AM Ellen Jane Cashin une /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Glen Burnie Baltimore Washington Medical Center If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Nov. 2, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M Connecticut 1919 XX 049-18-1789 87 Director Usual Residence of Decedent 10c. Cify, Town or Location 10d. Inside City Limits 10b. County 10a. State show "natural", or items 23a or 28a-f shov edical Examiner must be notified at 1 ☐ Yes XX No Director Maryland | Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21401 United States 2500 Painter Court ashin, Ellen Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give XX Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 3 Widowed 4 Divorced Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify If Yes, Charles Specify: Completed by White Item 27 Is marked other than "natu other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Nursing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be fi and Mental H Lawrence Hyland Bridget Keely 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 of Health Item 27 I 1302 Alderton Lane Silver Spring, Maryland 20906 John R. Cashin, Jr. / Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation A ☐ Other (Specify) Ft. Lincoln Crematory 6/19/2007 Brentwood, Maryland 21. Signature of Funeral Ser 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician emen resulting in death) /Medical Due to lor as a consequence of) Examiner sepsis Sequentially list conditions, if any, leading to immediate caus. Enter one rying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) signed by the a 1□Yes 2□No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 ☐ Yes should k Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? Yes 2 No certificate 1□ Yes director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient P 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di 27. Manne of Death 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury Certification: 28c. Injury at Work? 5 Pending investigation 1 Natural (Month, Day Year) Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

TROVER

Registrar's Signature

JUN 1 9 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Haspital Drive, Chen Burnie

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Lonbin JUNE 2007 /Medical 4c. County of Death acility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MEDICAL CENTER KEGIONAL Wicomico 8. Date of Birth (Month, Day, Year) ENINSULA PALISBURY If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 217-30-9540 1 ☐ M 2 💢 F Director MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits show traumatic event, the Medical Examiner must be notified at 1 X Yes 2 □ No Director MD ISBURI 23a or 28a-f 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21 Funeral Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 'natural", or Items 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No BLACK Specify: 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than any Injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) RN ABOR 3 ELIVERY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JAME 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1009 RIVERHOUSE HPT MD VAUGHN W. ORBIN~HUSBAND PALISBURY Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State PRINGHILL 4 Donation 5 Dother (Specify) HEBRON 21. Signaturé Funeral Service Licensee 22. Name and Address of Facility BENNIE SMITH FIH SBURY, MD ISABELLA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** pu monan andio /Medical Due to (or as a conse Lence of) Examiner Sequentially list conditions, if any, learning to include cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the death certificate be executed pentension and burial-trar Due to (or as a consequence of) Box 68760 attending physician Physician/Medical the use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Por in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) Division or Vital Records, P.O. the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2 **No** 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform certificate 1□ Yes 2 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No mpatient P 2 ER/Outpatient 3 DOA 28b. Time of 27. Manner of Death 28a. Date of Injury 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. gistrar's Signature

Easte

JUN 1 9 200

31. Date filed (Month, Day, Year)

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			<b></b>	Certificate of De	eath F	Reg. No. UU /	21629
		1. Decedent's Name (First, Middle, L			2. Date of Dea Month		3. Time of Death
	Physician /Medical	Yanira	Margarita	Dominguez		16,2007	1340
	Examiner	4a Facility Name (If not institution, g			City, Town, or Location of Death		George's
-		Prince George		The state of the s	Cheverly If Under 24 Hrs. 8. Date of Birth		_
	Funeral Director	5. Social Security Number 6.	Sex 7. Age (In y 1	Months Days	Hours Min /Month Day	y, Year) 4,1978 E1	irthplace (State or Foreign Country) Salvador
	면 >	Usual Residence of Decedent  10a. State 10b. County	100	City, Town or Location			10d. Inside City Limits
	anylau shov	MD Montgo	_	Silver Spring			1 ☐ Yes 2X No
	28a-1	10e, Street and Number	mer j	10f. Zip Code		10g. Citizen of What C	Country?
	23a or ust be n	2112 Belveder		2090		El Salv	
50	permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itams 23a or 28a-f show any Injury or other traumatic evant, the Medical Examinar must be notified at once.  To Be Completed by Funeral Director	11. Marital Status  1 □ Never Married 2 ★ Married  3 □ Widowed 4 □ Divorced	If Yes, Give	1 TYYes 2 □ No	panic Origin? (Specify Yes or No- Mexican, Puerto Rican, etc.)  Specify:	Black, Wh	
Maryland 21215-0020	2 hours atural", cal Ex	15. Decedent's	Year or Dates:	16a. Decedent's Usual Occupation (Give kind of work done dur life. DO NOT use retired)	El Salvadren	16b. Kind of Busines	s/Industry
121	ed within 72 horygiene.  Ner than "natura  It, The Medical Completed	(Specify only highest g Elementary/Secondary (0-12)	College (1-4or 5+)			Own Hon	ne
2	Hygien that the that the that the that the that the the the the the the the the the th	12 17. Father's Name (First, Middle, La	st)	Homemaker	8. Mother's Name (First, Middle,		
auc	ntal H ed oth	Andres Aliric			Margarita Ra	amirez	
2	hould by marked marked matic e	19a. Informant's Name/Relationship		19b. Mailing Address (Street and	nd Number or Rural Route Number		, Zip Code)
₹	nd 2 s Ith an 17 Is	Dan Rivas/Hus		2112 Belved	lere Blvd.Silve	er Spring	,Md 20902
ā,	s 1 ar f Hea item 2 othe	20a. Method of Disposition		b. Place of Disposition (Name of	Date	20c. Location - City of	or Town, State
Baltimore,	. Page ment o tant: If	1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	cify)	Gate of Heaven			tal viail
Ball	permit Depart Import any In	21. Signature of Funeral Service Lic	tunk	PHILIP D. 9241 Colu	RINALDI FUNE:	RAL SERVI lver Spr:	[CE,P.A. ing,Md20910
		23a. Part1. Enter the disease, or co	omplications that caused the colly one cause on each line.	death. Do not enter the mode of dying,	, such as cardiac or respiratory ar	rrest,	Approximate Interval Between Onset and Death
	Physician						Oliset and Death
<b>.</b>	/Medical Examiner	Immediate Cause (Finat disease or condition resulting in death)	a Septic	Shock			
*		resulting in dealin)	Due	to (or as a consequence of):			
	nsit		Ų	ral Pneumonia			
	executed in end iel-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due	to (or as a consequence of):			
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	rutificate be executed ng physician end as the buriel-transit	resulting in death) Last		atory Failure			
Box	eath cerratendin I for use		d Kespii	acory rarrare			
	at the death ce d by the attendi etached for us Physiclan/	Part II. Other significent condition	s contributing to death but not	resulting in the underlying cause given	n in Part I. 23b. Did	tobecco use contribu	ute to the cause of death?
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g,	signe d be c				24a. Was		b. Were autopsy findings
Š	v require been signaled should b				perfo	ormed?	available prior to completion of cause of death?
Vital Records,	The law require sate has been si page 2 should				1□	Yes 2 No	1 ☐ Yes 2 ☐ No
<u>a</u>	icate or, pag	25. Was case referred to medical			26. Place of Death (Check only		12.00
==	s certification of Be	examiner?  1 Yes 2 No	Hospital: 1 ☑ Inpatient	2 ☐ ER/Outpatient 3 ☐ DOA Other			pecify)
on of	ling Phy After this funeral c	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Yea	28b. Time of 28c. Injury Work?	at 28d. Describe ? Yes 2 □ No	how injury occurred	
Division of	To the Hospital or Attanding Physicien: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician end completely filled in by the tuneral director, page 2 should be detached for use as the buriel-transit Medical Certification: To Be Completed by Physician/Medical Examir	2 Accident investigation of Could not determine		At home, farm, street, factory, office pecify)	28f. Location ( City or To	(Street and Number or wn, State)	Rural Route Number,
٥	To the Hospital Within 24 hours a To the Funeral Completely filled Medical Ce	(Check only 2 Medical E	xaminer: On the basis of exam	knowledge, death occurred at the time mination and/or investigation, in my opi	e, date and place, and due to the inion, death occurred at the time,	cause(s) and manner , date and place, and	as stated. due to the cause(s)
	the thin 2 that in the mplet	one) 29b. Signature and title of certifier	and manner stated.	29c. License	number	29d. Date signed (Me	onth, Day, Year)
	5 × 5 0	1 /3/L. //	1) P KANAN	277	577	06/16	100
	2	30. Name and address of person w	to completed cause of death	(Item 23a) (Type, Print)	3 / /	11.0	, -/
		Ophnell Cu			al Dr. Cheve:	rly,Md 20	)785
	State	31. Date filed (Month, Day, Year)	32. Registrar's			•	
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			For Stete Registrer	State of I	Maryland		artment e			and M	ental Hyg	jiene leg. No.	07	21630
			Decedent's Name (First, Middle, Las	t)							2. Date of Dea Month	th	Yeer	3. Time of Death
	Physici /Medic		HENRY CARL	DeWA	ALL						JUNE	17 2	007	2:00 A M
	Examin		4a. Fecility Name (If not institution, give SHADY GROVE ADV			AL.	4b. City, To		Location o			4c. County		OMERY
	Funeral Director		5. Social Security Number 046-18-5173 6. Security Number 11	9X 7. ■ M 2□ F	Age (In yrs. I	ast birthday) Yrs.	If Under 1 Months	Year Days	Hours	Min.	8. Date of Birth (Month, Day OCt • 22	1923	Cour	place (State or Foreign ntry) ermany
	pur *		Usual Residence of Decedent  10a, State 10b, County		10c. City	, Town or Lo	cation						1	0d. Inside City Limits
	Maryli f ebo	ō	Md. Montgom	nery		Derwoo								1 □ Yes 2 No
	288 2011	rect	10e. Street and Number				10f. Zip C	ode				10g. Citizen of	What Cour	ntry?
	3a or	<u> </u>	18600 Azalea Driv	7e					208	55		Unit	ted S	tates
	death	ner	11. Marital Status	12. Was Decede			Was Deceder	nt of His	panic Orig	gin? (Spe	cify Yes or No-		e - Americ ck, White,	can Indian,
9	or its	by Funeral Director	1 ☐ Never Married 2 ☑ Married	1 ⊠Yes 2 If Yes Give	□No		1 ☐ Yes 2		Specify:	, 1 00110	riioari, etc.,	Specif		
8	within 72 hours after death with the Maryland ene. than "natural", or iteme 23a or 28a-f ehow ha Madical Exeminer must be notilled at	q p	3 Widowed 4 Divorced	Year or Date	s: WWI	Ι							VV.	hite
7	n 72	Completed	15. Decedent's Ed (Specify only highest gra	de completed)		Give	dent's Usual ( kind of work DO NOT use	Jccupat done du retired)	ion iring most	of worki	ng	16b. Kind of B	usiness/in	austry
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ğ	al Hyg	Bec	17. Father's Name (First, Middle, Last)						18. Mothe	r's Name	(First, Middle,	Maiden Suman	10)	
<u>ylai</u>	Ments Ments arked	To	Walter Carl I	DeWall					Pau	ıla	Норре	<u> </u>		
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural; or Iteme 23a or 28a-f ehow eny linury or other traumatic event, the Madical Examiner must be notified at once.		19a. Informant's Name/Relationship (7 Elsie L. DeWall ,								Derwood		State, Zip 208	
ore	of He fitem		20a. Method of Disposition 1 ™ Burial 2 □ Cremation 3 □	Bemoval from Sta		lace of Dispo emetery, crer	sition (Name natory or othe	of er place	) [	D	ate	20c. Location	City or To	own, State
Ě	Pag ment lant: I		4 □ Donation 5 □ Other (Specify		Nor	beck M					21/07		y, Ma	ryland
Bail	Departit Depart Impor eny in		21. Signature of Funeral Service Licen  Muruel II.	Bark	Ren	1					neral E aytonsvi		d. 2	0882
П			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that cau	sed the death h line.	n. Do not ent	er the mode	of dying	, such as	cardiac o	r respiratory ari	est, ·		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	a	Granul	omatou	s Lung	, Di	sease	Э				Weeks
	/Medical Examiner		resulting in death)	*	as a consequ						D-1	_		Years
		e	Sequentially list conditions, if any, leading to immediate	U	as a consequ		ructiv	e P	UTINOI	lary	Disease	-		
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events											
o	icate be executed physician and s the burial-transit	Еха	resulting in death) Last	Due to (or	as a consequ	uence of):								
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Box	es that the death certific igned by the attending p be detached for use as	Physician/Med	in the past 12 months?		me or pregna n 2 ∐ Fetal it at time of de	death 3	Ectopic preg						te of delive onth	ery Day Year
<u>о</u> .	the de y the ched	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknow		eatti 5	J Other (spec	пу)						
۳.	that	by Pr	Part II. Other significent conditions of	ontributing to deat	h but not resu	ulting in the u	nderlying cau	se giver	n in Part I.		23e. Did to	bacco use con	tribute to ti	he cause of death?
Division of Vital Records,	w require: been sig should by	ed b									1 □ Y	es 2 No	3 Prob	pably 4 Unknown
ဝင္ပ	law requ ss been 2 shouk	Completed									24a. Was a	an 24b.	Were auto	psy findings available mpletion of cause of
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ita	cien: artific	Be	25. Was case referred to medical examiner?								(Check only or			
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Ę.	ding I	tlon	27. Manner of Death  1 ☑ Natural 5 ☐ Pending  2 ☐ Accident investigation		Day Year)	28b. Time of Injury	M 280	: Injury Work?	at ? es 2⊡f	ĺ	28d. Describe h	ow injury occur	rea	
S	Attending Physicien: r death. ector: After this certifications the funeral director.	Certification;	3 Suicide 6 Could not be		Injury - At ho	ome, farm, str					28f. Location (S	treet and Num	er or Rura	al Route Number,
á	afor A after i Dire	ertl	4 Homicide	building	, etc. (Specify	1)					City or Tow	n, State)		
	To the Hospital or Attending Physicien: The lav within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical (	29a. Certifier 1 Certifying Ph	iner: On the basi	is of examinat	wledge, death	n occurred at vestigation, in	the time	e, date and inion, deat	d place, a	and due to the d ed at the time, d	ause(s) and mate	anner as s and due to	stated. the cause(s)
	o the ithin 2 the or the	Med	one) 29b. Signature and title of certifier	and manner	stated.		29c. l	icense	number		T :	29d. Date signe	d (Month.	Dey, Year)
)	F ≱ F 8		) Dain	2	0				4415	7				2007
	10+1		30. Name and address of person who	completed cause	of death (Item	23a) (Type.	Print)		-1-17	,				
			Ira Berger, M.D.			Seven		Roa	id, 1	Rock	ville,	Md. 20	854	
W.	Sta Registr		31. Date filed (Month, Day, Year) JUN 2 0 20	07 32 Reg	istrar's Signal	ture /	arti							

DHMH 17 Rev 1/2001

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### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hy	gier
Cartificate of Dooth	

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~	mar aqx	- 0	State Registrar							icate of				Reg. No.
19	Physicia		1. Decedent's Name		le, Last)		D	eMoi	celai	nd			2. Date of D Month June	eath Day 14
	/Medic Examin		4a. Facility Name (/						41	o. City, Town, o	r Location	of Death		4c.
		ĸű.	Heritage							Annapol				Ar
Ī	Funeral Director		5. Social Security N 579-07-42		6. Sex 1 ☐ M <b>XX</b>	7. Age	e (In yrs. i			Under 1 Year onths Days	If Unde Hours	Min.	8. Date of B (Month, D 2/26/1	ay, Year)
	D		Usual Residence of											
	ylan how at		10a. State	10b. County			10c. City	, Town	or Locati	on				
	Mal a-f s fied	Director	MD	Anne	Arunde1		Sh	ady	Side	2				
	r 28	ire	10e. Street and Nu	mber	_				1	10f. Zip Code				10g. Citi
	th wit		1718 Bay	View H	Rd.					2	0764			
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. If Health and Sa or 28a-f show sitem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1  □ Never Marr 3  □ Widowed		ried Armed	Decedent Ediforces?  es 2X1 No. Give  or Dates:		S.	If Y∈	Decedent of Hes, specify Cub	lispanic C an, Mexic Specif	an, Puerto	pecify Yes or N Rican, etc.)	0-
15-0	"natur	leted	(Spec	15. Deceder cify only highe	nt's Education est grade complete	ed)		16a. C	Decedent	t's Usual Occup d of work done NOT use retire	oation during mo	ost of work	king	16b. Ki
212	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Meone.	Completed	Elementary/Seco	indary (0-12)	Colleg	je (1-4or 5	+)		emak		u)			Ow
b	othe ent,	Be C	17. Father's Name	(First, Middle,	Last)						18. Moti	her's Nam	e (First, Middl	e, Maiden
/lar	uld be Venta Irked Itlc ev	To B	Miles Var	nSise							Et	he1	Curtis	
a	sho and l	•	19a. Informant's N	ame/Relations	ship (Type. Print)			19b. l	Mailing A	ddress (Street	and Num	ber or Ru	ral Route Num	ber, City o
Σ	alth alth 27 is	Ш	Robert De	Morela	and Hus	sband		171	8 Ba	ıy View	Rd.	Shad	y Side,	MD
Baltimore,	of He of He if item or othe		20a. Method of Disp		3 □Removal fr	om State	20b. P	lace of E emetery	Disposition, cremato	on (Name of ory or other pla	ce)		Date	20c. Lo
<u>Ē</u>	Pag ment ant: I ury o		4 □ Donation			o,,, olale	Ced	ar H	i11	Cemete:	ry	6/19	/2007	Sui
alt	permit. Departr Importa any Inj		21. Signature of Fu	ineral Service	icensee				22. N	ame and Addre	ess of Fac	ility Ha	rdesty	Fune
$\mathbf{\omega}$	Sa E E S		175~	٠, ۲, -	-W-				12 R	vlaohi	ATTO.	Δn	nanolie	MD

16b. Kind of Business/Industry

Specify.

Own Home

Citizen of What Country? USA 14. Race - American Indian Black, White, etc.

 $\overset{\mathsf{Day}}{14}$  ,  $200\overset{\mathsf{Year}}{7}$ 

4c. County of Death Anne Arundel

Time of Death

9. Birthplace (State or Foreign

10d. Inside City Limits 1 ☐ Yes 2 No

Washington, DC

White

9:05 alth

18. Mother's Name (First, Middle, Maiden Surname)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

cardiac arrhythmia

Husband 1718 Bay View Rd. Shady Side, MD 20764 Date 20a. Method of Disposition 20c. Location - City or Town, State

6/19/2007 Suitland, MD 22. Name and Address of Facility Hardesty Funeral Home, P.A.

12 Ridgely Ave. Annapolis, MD 21401

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each the Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** 

Physician/Medical Examiner

þ

Completed

Be

Certification:

Medical

attending physician and for use as the burial-tran

signed by the and be detached for

cate has t

funeral director.

completely filled in by the

certificate

After this

Director:

within 24 hours a

To the Hospital or Attending Physician:

The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

Sequentially list conditions, any leading London London Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

7

Due to (or as a consequence of) Due to for as a consequence of

Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown

23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death

4☐Pregnant at time of death 9☐Unknown 5 Other (specify)

2 ER/Outpatient 3 DOA

3 Ectopic pregnancy

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

5 ☐ Residence 6 ☐ Other (Specify)

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

Year

Approximate Interval Between Onset and Death

24a. Was an autopsy

performed 1□ Yes 2□No 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? Hospital: 20 No 1 ☐ Yes 1 🔲 Inpatient 27. Manner eath

Mitural 5 Pending investigation Accident

28a. Date of Injury (Month, Day Year) 28b. Time of Injury 6 □ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined

Other: Nursing Home 28c. Injury at Work? 1 Tyes 2 No

28d. Describe how injury occurred Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

3 Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and

29d. Date signed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, JUN 1 9 2007

Registrar

State

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland Department of Health and Mental Hygiene 25a-f per me, 8869,0//17/07dbb Reg. No. 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death June 14<sup>Day</sup>2007<sup>ear</sup> Jose Gregorio Esperanza 11:33°° 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George's 13104 Golden Oak Drive Laurel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7/13/1954 9. Birthplace (State or Foreign Country)

21 Salvador 7. Age (In yrs. last birthday) Social Security Number Days Months Hours 52  $\mathbf{E1}^{\circ}$ 220-31-6916 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County MD Prince George's Laurel 1 ☐ Yes 2 ☐ No 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 13104 Golden Oak Drive 20708 El Salvador 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces' Black, White, etc. 1 □ Yes 2 No If Yes, Give 1 Never Married 2 Married 1 x Yes 2□ No Specify Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: E1Salvadore 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Church 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Beatriz Melara Esperanza unobtainable 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13104 Golden Oak Drive Laurel, Md. 20708 Carlos Esperanza/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Gate of Heaven 6/19/2007 Silver Spring, Md 21. Signature Funeral Servic Vicense PHILIP AD RINALDI FUNERAL SERVICE, P.A. 9241 columbia Blvd.Silver Spring, Md20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final phyxin Tion disease or condition resulting in death) Due to (or s a onsequence of): Han Due to (or as a consequence of) Due to (or as a consequence of) 23c. If ves. outcome pf pregnancy 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 □Ectopic pregnancy Month 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed'

**Physician** /Medical Examiner

Physician

/Medical

Examiner

**Funeral** 

Director

"natural", or items 23a or 28a-f show edical Examiner must be notified at

Baltimore, Maryland 21215-0036

Director

Funeral

Completed by

Be

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the death certificate be executed attending physician a for use as the burial-

P.O. Box 68760

Records,

Vital

o

Division

To the Hospital or Attending Physician:

Examiner

signed by the a page 2 s certificate this

by Physician/Medical Completed Be Certification: To funeral within 24 hours after death

To the Funeral Director: /

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1□Yes 2□No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 21 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 □ Natural 5 ☐ Pending investigation Hung himself with electrical 06/14/2007 2333 1 ☐ Yes 2 XNo 2 ☐ Accident cord 6 Could not be determined 3 Suicide (Street and Number or Rural Route Number, 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 13104 Golden Oak Drive, Laurel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32 Segistrar's Signature 31. Date filed (Month, Day, Year) 2007

State Registrar

Medical

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Robert F. Fenton 18 2007 June 6:18  $\mathbf{P}^{\mathsf{M}}$ /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 922 Breakwater Drive Anne Arundel Annapolis Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 336-12-2405 150 M 2 ☐ F 85 Director Illinois April 5, 1922 Usual Residence of Decedent 10a State 10b. County 10c, City, Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Anne Arundel Annapolis Maryland 1 X Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21403 922 Breakwater Drive U.S.A. death v Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes **2**CXNo White If Yes, Give 1942–46 Year or Dates:1942–46 Specify: 3X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other two. Elementary/Secondary (0-12) College (1-4or 5+) U.S. Park Service Historian 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be unknown Elizabeth Faulkner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Newell/personal rep. 621 Ridgely Ave. #400 Annapolis, Maryland 21401 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ₩ Burial 2 Cremation 3 Removal from State Parklawn Mem. Gardens 6/22/2007 | Rockville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signal red Funeral S rvice Licensee 22. Name and Address of Facility John M. Taylor Funeral Home odal 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician olonory dis. Luce 8 d disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner 128 TX Sequentially list conditions Directo (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the death certificate be executed the burial-transit Due to (or as a consequence of) Box 68760. attending physician Physician/Medical as 1 for use a IF FEMALE yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) P.O. ☐Yes 2☐No the 9☐Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has autopsy performed certificate 2 1No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient ၉ 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After Injury (Month, Day Year) 1 Natural 5 Pending M 2 Accident 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) by 4 Homicide filled in 1-Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30718 2007 son who completed cause of death (Item 23a) (Type, Print) 30. Name and address of pe egrele , MO 21401 ) cocken 2003 Lead 31. Date filed (Month, Day, Year) egistrar's Signature JUN 2 0 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Carroll Handsin Forrest June 20 2007 3:15A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Vindobona Nursing Home Braddock Heights Frederick If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Oct 31 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**%** M 2 □ F Oct 219-03-6547 99 1907 Brunswick, MD Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show Examiner must be notified at MD Frederick Brunswick 1XYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 238 1201 Maple Terrace 21716 IISA Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No Navy If Yes, Give 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 "natural", or If Yes, Give Year or Dates: 1929-33 1 ☐ Yes 2 🔀 No White Specify: þ 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) B&O Railroad than, Elementary/Secondary (0-12) College (1-4or 5+) Brunswick & Baltimore MD Brakeman Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Forrest Winona Gaver ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any Injury or other trau Winona B. Long, Daughter 7434 Round Hill Road, Frederick, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Park Heights Cemetery 6/23/07 Brunswick, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Ligenstee / Barbara A. Williams, Owner 22. Name and Address of Facility John T. Williams Funeral Home 100 Petersville Road, Brunswick, 21716 Approximate
Interval Between
Onset and Death
O QQS 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final neumonia Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician for use as the buria Division or Vital Records, P.O. Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Dav 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 √nknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No has autopsy performe 2 **☑** No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Medical Certification: After (Month, Day Year) Injury 1 Natural 5 □ Pending 1 □ Yes 2 □ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

within 24 hours after death

To the Funeral Director: A the Hospital

22037

AUG

29d. Date signed (Month, Day, Year) 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

inland th, Day, Year) JUN 2 1 2007 31. Date filed (Month, 32. Registrar's Signature

Registrar

29a, Certifier

(Check only one)

29b. Signature and title of certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

4a. Facility Name (If not institution, give Homewood At Crum 5. Social Security Number 6. Se	urness estreet and number) mland Farms ex O M 2 M F  10c. ick	nrs. last birthday)  88 Yrs.  City, Town or Lo	F1  If Under 1  Months  ccation	rederi	cation of Death  Ck  Under 24 Hrs. ours Min.	2. Date of Death Month June  8. Date of Birth (Month, Day, Sept. 5,	Day 16, 2 4c. County Fr	eder	3. Time of Death 5:20 A
Margaret S. Ft.  4a. Facility Name (If not institution, give  Homewood At Crum  5. Social Security Number  150-32-7192  Usual Residence of Decedent  10a. State  10b. County  Maryland  Frederic  10e. Street and Number  7407 Willow Road  11. Marital Status  1 Never Married  2 Married  3 Novidowed 4 Divorced	e street and number) mland Farms ex  □ M 2 \	88 Yrs.	F1  If Under 1  Months  ccation	rederi	.ck Under 24 Hrs.	8. Date of Birth	4c. County	of Death eder:	
4a. Facility Name (If not institution, give  Homewood At Crum  5. Social Security Number  150-32-7192  Usual Residence of Decedent  10a. State  10b. County  Maryland Frederic  10e. Street and Number  7407 Willow Road  11. Marital Status  1 Never Married  2 Married  3 Novidowed 4 Divorced	mland Farms    Tarms   Tarms	88 Yrs.	F1  If Under 1  Months  ccation	rederi	.ck Under 24 Hrs.	(Month, Dav.	Fr	eder	ick
5. Social Security Number 150-32-7192  Usual Residence of Decedent 10a. State 10b. County  Maryland Frederic 10e. Street and Number 7407 Willow Road 11. Marital Status 1 Never Married 2 Married 3 Novidowed 4 Divorced	ick  7. Age (In y	88 Yrs.	If Under Months	1 Year   If	Under 24 Hrs.	(Month, Dav.			ick
150-32-7192	ick  12. Was Decedent Ever in Armed Forces?	88 Yrs.	Months			(Month, Dav.	Vaar)		LCK
Usual Residence of Decedent  10a. State  10b. County  Maryland  Frederi  10e. Street and Number  7407 Willow Road  11. Marital Status  1 Never Married  2 Married  3 Novidowed 4 Divorced	ick  12. Was Decedent Ever in Armed Forces?	00				Sept.5.	1001)	9. Birthp	place (State or Fore ntry)
10a. State 10b. County  Maryland Frederic  10e. Street and Number  7407 Willow Road  11. Marital Status  1 Never Married 2 Married  3 Novidowed 4 Divorced	ick  d  12. Was Decedent Ever in Armed Forces?	City, Town or Lo					1918		Jersey
Maryland Frederic 10e. Street and Number 7407 Willow Road 11. Marital Status 1 Never Married 2 Married 3 Novidowed 4 Divorced	ick  d  12. Was Decedent Ever in Armed Forces?	City, Town of Ec						— Т,	10d. Inside City Lim
11. Marital Status 1 Never Married 2 Married 3 Novidowed 4 Divorced	d 12. Was Decedent Ever i								1 ☐ Yes 2X
11. Marital Status 1 Never Married 2 Married 3 Novidowed 4 Divorced	12. Was Decedent Ever in Armed Forces?			<u>erick</u>				$\perp$	
11. Marital Status 1 Never Married 2 Married 3 Novidowed 4 Divorced	12. Was Decedent Ever in Armed Forces?		10f. Zip (			10	ng. Citizen of V	Vhat Cour	ntry?
3 □XVidowed 4 □ Divorced	Armed Forces?			21	.702		Unite	d Sta	ates
3 □XVidowed 4 □ Divorced		n U.S. 13.	Was Decede	ent of Hispar	nic Origin? (Sp	ecify Yes or No- Rican, etc.)		e - Americ k, White,	can Indian,
	1 ☐ Yes 2X No If Yes, Give			∑XNo S		,	Specify		White
15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	Year or Dates:		103 2	2110 0			Specily		WIIICC
Elementary/Secondary (0-12)		16a. Dece	dent's Usual	I Occupation	n ng most of work	ing 1	16b. Kind of Bu	ısiness/In	dustry
5	College (1-4or 5+)	life.	DO NOT use	e retired)	<b>3</b>				
Ŏ.	+3	Ad	minist	trator	:		E	duca	tion
17. Father's Name (First, Middle, Last)				18.	Mother's Name	e (First, Middle, N	laiden Sumam T = 1	.e) 11 i ατ	Hoddw
Lawrence Suther	rland				Lillia	mEuther:	land Li	LIIdi	1 Heddy
	Type, Print)	19b. Maili	ng Address	(Street and	Number or Run	al Route Number,	City or Town,	State, Zip	Code)
Margery Brubaker	/ Daughter	7164	Glenr	meadow	Court	Frederi	ick, MD	217	03
20a. Method of Disposition	20	b. Place of Dispo	osition (Nam	ne of		Date 2	20c. Location -	City or To	own, State
		-	-		6/20	1/2007 1	Frederi	ck 1	Maryland
1					1			-	•
21. Signature of Funeral Service Licens	1	2							
1 our ney	Jaugger					-		CK, I	
Immediate Cause (Final disease or condition			ter the mode	e or ayıng, sı	uch as cardiac	or respiratory arre	St,		Approximate Interval Between Onset and Death
			ه د ۱	- Ac	CUDE	NT			15 month
if any, leading to immediate cause. Enter Underlying			1. 1.			4			4 4 cans
Cause (Disease or injury that initiated events	0.	•	VICE TT	CYI				-	1 years
w lesuting in death, cast	Due to (or as a con	isequence of):							- 0
Ca	d								
0									
23b. Was decedent pregnant			Tectonic pre	egnancy					•
in the past 12 months?	4☐ Pregnant at time						Mo	nth	Day Year
9 □ Unknown	9∟ Unknown								
Part II. Other significant conditions of	ontributing to death but not	resulting in the u	underlying ca	ause given in	Part I.	23e. Did tob	acco use cont	ribute to t	he cause of death
9						1 ☐ Ye	s 2 No	3 Prot	babły 4 ∏Unkn
9						242 1650 25	24h 1	Moro put	anny findings avail
Ē						autops	v _ r	prior to co	empletion of cause
8									2 No
25. Was case referred to medical					. Place of Deat	h (Check only one	э)		
O 1 ☐ Yes 2 No	1   Inpatient				4 Nursing Ho				fy)
	28a. Date of Injury (Month, Day Yea	28b. Time o	of 28	8c. Injury at Work?		28d. Describe ho	w injury occurr	ed	
2 Accident investigation	1		М		2 🗌 No				
3 Suicide 6 Could not be determined	286. Place of Injury - A	At home, farm, st	reet, factory,	, office				er or Run	al Route Number,
-	Summing, etc. (Sp	,,,,,				5.1, G/ 10#//	, 5.0.0,		
	ysician: To the best of my ninar: On the basis of exan and manner stated.	knowledge, deat mination and/or in	th occurred a nvestigation,	at the time, o	date and place, on, death occur	and due to the ca red at the time, da	use(s) and ma ate and place,	inner as s and due t	stated. to the cause(s)
-	7	7	29c	. License nu	mber	29	9d. Date signe	d (Month.	Day, Year)
Variable 1	100cms	Cer us							
- Ilwan !		-			1	1	0-10.		
30. Name and address of persop who	annulated 1.1	(14	Delecti				- 1		
edical Certification; To Be Completed by Physician/Medical Examiner	Margery Brubaker  20a. Method of Disposition  1	1	19a. Informant's Name/Relationship (Type, Print)   19b. Mail   Margery Brubaker / Daughter   7164	19a. Informant's Name/Relationship (Type, Print)   19b. Mailing Address   Margery Brubaker / Daughter   7164 Glem   7164 Gle	19a. Informant's Name/Relationship (Type, Print)  Margery Brubaker / Daughter  20a. Method of Disposition    Burial   2   Gremation   3   Removal from State	19a. Informant's Name/Relationship (Type, Print)  Margery Brubaker / Daughter  7164 Glenmeadow Court. 7162 Glenmeadow Court. 7162 Glenmeadow Court. 7164 Glenmeadow Court. 7164 Glenmeadow Court. 7164 Glenmeadow Court. 7164 Glenmeadow Court. 7162 Glenmeadow Court. 7162 Glenmeadow Court. 7162 Glenmeadow Court. 7162 Glenmeadow Court. 7164 Glenmeadow Court. 7164 Glenmeadow Court. 7162 Glenmeadow Court. 7164 Glenmeadow Court. 7162 Glenmeadow Court. 7164 Glenmeadow Court. 7162 Glenmeadow Court. 7162 Glenmeadow Court. 7162 Glenmea	19a. Informant's Name/Relationship (Type, Print)  Margery Brubaker / Daughter  20a. Washood of Disposition 1   David 2   Ceramaton 3   Removal from State   20b. Place of Disposition (Name of ceremetry, Ceramatory) of April 1   Certifying Physician: To the bast of misposition (Name of ceremetry)   Ceramatory of April 1   Ceramatory   Ceramato	Lawrence   Suther Hand   Supposition   1   198. Mailing Address (Street and Number or Rural Router Hand   198. Mailing Address (Street and Number or Rural Router Hand   198. Mailing Address (Street and Number or Rural Router Hand   198. Mailing Address (Street and Number or Rural Router Hand   198. Mailing Address (Street and Number or Rural Router Hand   198. Mailing Address (Street and Number or Rural Router Hand   198. Mailing Address (Street and Number or Rural Router Hand   198. Mailing Address (Street and Number or Rural Router Hand   198. Mailing Address (Street and Number or Rural Router Hand   198. Mailing Address (Street and Number or Rural Router Hand   198. Mailing Indian   198. Ma	19b. Informant's Name-Relationship (Type, Print)  Margery Brubaker / Daughter  19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zit Malling Address)  19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zit Malling Address)  20a. Method of Disposition  1

DHMH 17 Rev 1/2001

Grounto Anysician as: Margaret turness

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 7:27 AM DELMONT FRYE UNE 16 200 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner NLABALTMORE UNIVERSITY OF WINGLAND MEDICAL CENTER Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Social Security Number 6 Sex 7. Age (In yrs. last birthday Date of Birth (Month, Day, Year) **Funeral** Months 1 1 M 2 □ F 216-90-8803 36 Director 7/5/1970 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Wicomico Hebron Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21830 USA Porter Mill Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: white Specify è 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) machine operator E.I. Dupont Co. 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Linda Lee Scott Delmont R. Frye ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Delmont R. Frye/father 710 Buckingham Circle, Salisbury, MD 21804 Date 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Wicomico Memorial 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/20/07 Salisbury, MD Park 22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Sanature of Funeral Sur ant1. Enter the disease, or complications a hock, or heart failure. List only one car se o caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. Immediate Cause (Final Physician PNEUM=~!A disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ACUTE LIMPHOBLASTIC LEVKEMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2☐No 9□Unknown 9 HInknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy perform 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ို 27. Manner of Death 1 Natural 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier P19831 2007 MD Dr. Gr 21201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Graham Snyder

DHMH 17 Rev 1/2001

State

Registrar

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31. Date filed (Month, Day, Year) JUN 19

GREENE

ST

2007

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

BALTIMORE

32. egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 2. Date of Death 3. Time of Death . Decedent's Name (First, Middle, Last) Month Year **Physician** 2:45P™ 2007 12 June Raquel Gonzalez-Santiago /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Potomac Manor Care Potomac Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Min. Months Days Hours 1 ☐ M 2 🖫 F 73 Yrs. 03-25-1934 Puerto Rico Director 062-26-3016 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County or Itams 23a or 28a-f show 1 ☐ Yes 2 No Director Maryland | Montgomery Takoma Park 10g, Citizen of What Country? 10e. Street and Number 20912 United States 1100 Linden Avenue #202 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ant of Health and Mental Hygiene. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1X Yes 2□ No þ 3 Widowed 4 Divorced Puerto Rican Mixed Races ted 16b. Kind of Business/industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Complet Elementary/Secondary (0-12) College (1-4or 5+) Retail 12 Sales Associate 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Santiago Eugenia Esteban Gonzalez Piris 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) 1100 Linden Ave., #202, Takoma Park, MD 20912 Dr. Tony Medina-Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages Department of Important: If it. 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Ft. Lincoln Crematory 6/21/07 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, Maryland 9 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Simple Tribute 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final years End stage Pulmonary Fibrosis **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine signed by the attending physician and to detached for use as the burial-transit certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23h. Was decedent pregnant 3 Tectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ♣ No Year Month Dav 4☐Pregnant at time of death 5 Other (specify) Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Pulmonary Hypertention, Diabetes mellitus 1 Yes 2X No 3 Probably 4 Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an Coronary artery disease 1 Yes 2**X** No Division of Vital al or Attending Physician: T s after death. al Director: After this certificat sd in by the funeral director, ps Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 41 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27 Manner of Death 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specily) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D31319 June 13, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Loreto S. Albiol, M.D.-8218 Wisconsin Ave., Suite 305, Bethesda, Maryland 20814 31. Date filed (Month, Day, Year) 32. A istrar's Signature

DHMH 17 Rev 1/2001

Registrar

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760 I Director: # To the Funeral within 24 |

Physician

/Medical

**Examiner** 

**Funeral** 

Director

an "natural", or items 23a or 28a-f show Medkai Examiner must be notifled at

permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturar", or items 23s any Injury or other traumatic event, the Medical Examiner must any Injury or other traumatic event, the Medical Examiner must once.

**Physician** /Medical

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

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Examiner

Physician/Medical

Completed by

Be

Certification: To

Medical State

Registrar

31. Date

JUN 2 0 2007

cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

21620 Matter King M.D

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2007 June 17 0158 Barbara A. Harris 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Jan 2 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Months Days Hours 1 □ M 2**X** F 65 Yrs. 217-58-2676 Maryland Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits TY Yes 2 □ No Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1167 Frederick Douglas St. 21403 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2X No Specify Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 11th 0 Homemaker None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Willie Shelly Barbara Diggs 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 1 4 0 3 19a. Informant's Name/Relationship (Type. Print) 1167 Frederick Douglas St. Annapolis, Md. Daphyne Holland (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State

**Physician** /Medical

Department of Health ar Important: If item 27 Is any Injury or other trau

**Examiner** 

**Physician** 

/Medical

**Examiner** 

10a. State

**Funeral** 

**Director** 

"natural", or Items 23a or 28a-f show dical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after death vant of Health and Mental Hyglene.
Then to f Health and Mental Hyglene.
The marked other than "natural", or thems 23.
The coher traumatic event, the Medical Examiner must ury or other traumatic event, the Medical Examiner must

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

Be

physician and the burial-transit as use certificate has been si rector, page 2 should funeral director, within 24 hours after death

To the Funeral Director:
completely filled in by the in by 1

or Attending Physician: The law requires that the death certificate be executed

To the Hospital

Box 68760,

P.O.

Division or Vital Records,

21. Signature of Funeral Service Licensee Ree 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Physician/Medical IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 25. Was case referred to medical 1 Yes 2 No Medical Certification: To 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 4 Homicide 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

4 □ Donation 5 □ Other (Specify)

. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4☐Pregnant at time of death 9☐ Unknown

M0048

aspiration

metastatic

Du to (or as a consequence of):

Due to (or as a consequence of)

Due to (or as a consequence of)

3 ☐ Ectopic pregnancy 5 ☐ Other (specify)

Maryland Veteran 6-25-07

Winname Revocase of Moilicons Mortuary, P.A. 821 West St. Annapolis, Md. 21401

> 23d. Date of delivery Month Day

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

23e. Did tobacco use contribute to the cause of death?

Crownsville, Md.

Approximate Interval Between Onset and Death

Year

2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work?

28a. Date of Injury (Month, Day Year) Injury 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1/Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1⊟ Yes

29b. Signature and title of certifier

29c. License number D58510 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Mohth, Day, Year)

JUN 2 0 2007

gistrar's Signature

State Registrar Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	1	For State Registrar	State of	Maryland		tificate of L			giene Reg. No.	07	21540
W 1 15		Negistrar     Necedent's Name (First, Middle, La	st)					2. Date of De	ath		3. Time of Death
Physicia		Ruthann Leo	nard H	umphre	ys			June	27 <sup>pay</sup> 2	20 0 7	1:15 AM
/Medica Examine		4a. Fecility Name (If not institution, giv				4b. City, Town, or	Location of Dea	th	4c. Coun	ty of Deeth	
		Dove Hospice	House			Westmin	nster		Car	roll	
Funeral		5. Social Security Number 6. S	ex □M 2XTF	7. Age (In yrs. la		If Under 1 Year Months Days	If Under 24 Hrs Hours Min	(Month, Da	v. Year)	9. Birth	olace (State or Foreign
Director	-	203-32-1812	UM 201	64	Yrs.			April 1	., 1943		PA
and	-	Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	cation		·			10d. Inside City Limits
Marylan f show	ō	MD Howard	<b>a</b>	T	aure	1					1 ☐ Yes 2 XNo
ith the M or 28a-f	Director	10e. Street and Number	4		Juli	10f. Zip Code			10g. Citizen o	f What Cou	ntry?
h with		9328 Breamore	Court			2072	23		U.S	S.A.	
ems	Funeral	11. Marital Status	1	dent Ever in U.S	. 13. \	Vas Decedent of Hi f Yes, specify Cuba	spanic Origin? ( n. Mexican, Pue	Specify Yes or No	14. R	ace - Ameri ack, White,	
ours after death with the Maryla al', or Hems 23a or 28a-1 shov	by Fu	1 Never Married 2 Marned	1 ☐ Yes If Yes, Giv	2 <b>½</b> ] No e		I□Yes 2♣No	Specify:		Spec	ify: Wh	ite
72 hours after death w netural', or Items 23a		3 ☐ Widowed 4 ☐ Divorced  15. Decedent's E	Year or Da	ates:	16a Dece	lent's Usual Occupa	ation	150	16b. Kind of		
in 72	Completed	(Specify only highest gra	de completed)		(Give	kind of work done of NOT use retired	lurina most of wo	orking	Resea	_	•
y with jiene.	E	Elementary/Secondary (0-12)	College (1	. ' 1	Techn	ical Lib	rarian		Devel		
be filed within 72 hours atter death with the Maryland ital Hygiene. d other than "netural", or items 23a or 28a-f show event, "the Moulcal Exc. utrer is and be inclified at	Bec	17. Father's Name (First, Middle, Last	)				18. Mother's Na	ame (First, Middle,	, Maiden Sum	ame)	
Menta Menta arked atic e	٥	John L. Leona:	rd					lla Jud			
2 should and Men is marke aumatic		19a. Informant's Name/Relationship (	**	<b>.</b>		g Address (Street a					
ges 1 and 2 should be filed within 72 hc to Health and Mental Hygiene. If Item 27 is marked other than "netur or other traumatic event, the Madical	1	Richard W. Hum  20a. Method of Disposition	phreys,			8 Breamo sition (Name of	ore Ct.	., Laur	el, ML 20c. Location		
permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if Item 27 is marked other than any injury or other traumatic event, Item 2006e.		1 Surial 2 Cremation 3		State Cer	metery, crer	natory or other plac	1,1110	ie_30,		•	
it. Pg intmediations injury	-	<ul> <li>4 □ Donation 5 □ Other (Special</li> <li>21. Signature of Funeral Septice Lice</li> </ul>		Rou		11 Cemete					A 17322 wary Inc.
permit. Departr Importa		Madel E/	Menn			9 S. Mai					
V-V-TTL-		23a. Part1. Enter the disease, or com	plications that c	aused the death.							Approximate Interval Between
Physician	-1	shock, or heart failure. List only Immediate Cause (Final	one cause on e	7 10	one:	100	CAN	Ken			nset and Death
/Medical	1	disease or condition resulting in death)	a. Due to (	or as a conseque	ence of):	7 1770	C' L'				17-10
Examiner		Sequentially list conditions	b								
A R E	Iner	if any, leading to immediate cause. Enter Underlying	Due to (	or as a conseque	ence of):						
and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	or as a conseque	ence of):						
ate be executed hysician and the burial-transit	<u>8</u>										
The cold us, T.C. BOX 00100,  The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	edical		_ d								
anding use a	hysician/Med	IF FEMALE: 23b. Was decedent pregnant		come of pregnan		Testania araganas				Date of deliv	*
death	sicia sicia	in the past 12 months? 1 Yes 2 No		ant at time of dea		Ectopic pregnancy Other <i>(specify)</i>				Month	Day Year
at the by the stache	Phys	9 🗍 Unknown									
wrequires that the death certific been signed by the attending p should be detached for use as I	ò	Part II. Other significant conditions	contributing to de	eath but not resul	ting in the u	nderlying cause give	en in Part I.		robacco use co Yes 2 □ No		the cause of de ? bably 4 7 nknown
requir seen si hould	eted	Samoir	V/Y/SO	213/	1,0						1853
e law has t	Completed	Confloria	HULT	- Sai	LUNC			24a. Was auto	nsv	prior to co death?	opsy findings available ompletion of cause of
vician: The lav certificate has rector, page 2		05 11/							ormed? 2X No	1 🗆 Yes	2 No
sicia s certi	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	npatient 2 E	R/Outpatier	t 3 DOA Oth	0.5	eath (Check only only only only only only only only	/	ther (Speci	(M)
g Phys er this eral dir	-	27. Mayor of Death	28a. Date of		28b. Time o		y at	28d. Describe			1100
ath.	atlo	Natural 5 Pending investigation	n	iri, Day 10ui)	injury		Yes 2 □ No				
r Atte	Certification:	3 Suicide 6 Could not to determined	288. Place	of Injury - At hor ng, etc. (Specify)	ne, farm, str	eet, factory, office		28f. Location ( City or To	'Street and Nui wn, State)	mber or Rui	ral Route Number,
oitel o								<u> </u>			
To the Hospitel or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical	29a. Certifier (Check only one)  Certifying P  Medical Exa	miner: On the ba	best of my know asis of examination ner stated.	viedge, deat on and/or in	n occurred at the tin vestigation, in my o	ne, date and plai pinion, death oci	ce, and due to the curred at the time,	cause(s) and date and plac	manner as e, and due	stated. to the cause(s)
o the o the omple	Me	29b. Signature and title of certifier	7	101 9,0100		29c Licensi	e number		29d. Date s/g	ned (Month	Day, Year)
r s r ō		> /				116	303	1	60	27/	7.007
	-	30. Name and address of person with	completed caus	e of death (Item	23a) (Type,	Print)	, 1 -		./	1/	0
15		Jousuf Gry Jour	555	South	Cer	ter Stre	et W	SIMIL	ster	MD	010)
Stat		31. Date filed (Month, Vay Year)	77 22. R	egistrar's Signati	иге ДОМ	S. S. S.					
Registra	11	JOT A 2 FOR	A STATE OF THE STA	A	1						

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State of Maryland / Department of Health and Mental Hygiene

Linda Christine Hoo	1- For State	tate of Marylan	d / Department of Certificate of		d Mental Hy	ygiene Reg	200	17 2164		
Physician/						2. Date of Death	Day Year	3. Time of Death		
Medical Examine	HINGG ONLIGGE	Linda Christine Hooker					07	2035 hrs		
*	4a. Facility Name (if not institution, give street and number) 4b. C 25 Pennsylvania Avenue				Location of Death		4c. County of Dea Anne Arunde	·I		
Funeral Director	5. Social Security Number 212-66-7115	6. Sex 7.	Age (In yrs. last birthday) 54	If Under 1 Year  Months Days  rs.		_	(MM/DD/YYYY) 9. B Fore	irthplace (State or ign Washingto ountry)		
	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Loc	ation				10d. Inside City Limits		
d d d d d d d d d d d d d d d d d d d			1			à .		1 Yes 2 X No		
the Maryland a or 28a-f sh iified at our	MD Anne 10e. Street and Number	Arundel	Edgewat	10f. Zip Code		100	. Citizen of What Co	untry?		
ore, MD 21215-0036 set 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If fitten 27 is marked other than "natural", or items 23a or 28a-f show ther traumatic event, the Medical Examiner must be notified at outce.  To Be Completed by Funeral Director	25 Penna Ave. 21037 USA									
or items 22	11. Marital Status 1 Never Married 2			Vas Decedent of His Yes, specify Cuban			14. Race - Ame White, etc.	rican Indian, Black,		
er deat , or it.	Widowed 4 XD	1 Yes	2 X No	Yes 2 X No			Specify: Ta	hite		
15-0036 Iffled within 72 hours after 1 Hygiene, a of other than "natural", of the Medical Examiner 1.	15 Decedes to Education (Se	or Dates:		ent's Usual Occupat	tion (Give kind of w		16b. Kind of Business			
5-0036 ed within 72 hour lygiene. other than "natt. the Medical Exal	Elementary/Secondary (0-12	) College (1-4	or 5+) during	most of working life.	. DO NOT use retii	red)				
DO3( within jee. rer that Medic	12		Home	maker	40.14.15.15.11	deline section sec	Own Home			
215-( 215-( be filed ntal Hyg riked offi ent, the					18.Mother's Name		•			
212 212 Duld be I Ment mark ic eyer			19b. Mail	ing Address (Stree		ara Edwards er or Rural Route Number, City or Town, State, Zip Code)				
imore, MD 2121 Pages 1 and 2 should be filment of Health and Mental 1 tant; if iten 27 is marked or other traumatic event, To Be	Andrew Denham	Hooker So					, MD 2103			
ore, s I and of Heal	20a. Method of Disposition 1 X Burial 2 Crematic	on 3 Removal from		osition (Name of cer other place)	metery,	Date	20c. Location - City of	or Town, State		
Baltimore, permit. Pages I an Oepartment of Hee Important: If ite injury or other tr	4 Donation 5 Other	Specify:	Our Lady	of Sorrow	7s 6/2	9/2007	Owensvill	e, MD		
Baltimore, ME permit. Pages I and 2 sl Department of Health at Important: If item 27 injury or other trauma	21. Signature of Funeral Sovice	e Licensee					meral Hom			
Physician	23a. Part I. Enter the disease, of	or complications that caus	sed the death. Do not ente	r the mode of dying,	such as cardiac o	r respiratory arres	MD 21401 st, shock, or heart	Approximate Interval		
/Medical	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Approximate Interval Between Onset and Death  Death									
raminer	or condition resulting in death)	Due to (or as a co	onsequence of):	diction and	<u> </u>					
	Sequentially list conditions, if any, leading to immediate	b Due to (or as a co	onsequence of):							
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outed nd ransit Examiner		Due to (or as a consequence of):  d								
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68760 Sertificate I Iding physise as the bu	9 by FFEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 23b. Was decedent pregnant in the 25b.				23d. Date of delive					
x 68 h certi tendin use as	23c. If yes, outcome of pregnancy 1					Day 100				
P.O. Box 68766 that the death certificate ned by the attending phy detached for use as the Loy Physician/Me	1 Yes 2 V No 9 Unknown g Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?									
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duires en sig						24a. Was a		autopsy findings available		
Records, The law require: ficate has been sig. page 2 should be Completed						autops	y prior to ned? death?	completion of cause of		
of Vital Records,  ng Physician: The law require ther this certificate has been simeral director, page 2 should the				26 Place	e of Death (Check	1 Yes 2	No1 ✓	Yes 2 No		
Vital I hysician: this certiff I director,	examiner?	Haspital	patient 2 ER/Outpatie	(=)	Oth series		Residence 6 🗸 Oth	er: Scene		
of \ og Phy og Phy of refer the	27 Manner of Death	28a. Date of (Month, D	Injury 28b. Time o	of Injury 28c. Inju	ry at Work?	28d. Describe ho	ow injury occurred			
ion of Ntending Phyleath. tor: After ti the funeral	1 X Natural 5 Pe 2 Accident Inv	nding estigation		1,	Yes 2 No					
Division o  Division o  Hospital or Attending 24 hours after death. Femeral Director: Aft sely filled in by the fune	3 Suicide 6 Co	28e Place of Injury - At home, farm, street, factory, office building, etc. 28f, Location (Street and Number or Rural Route N						Rural Route Number, City		
29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) (Check only one) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place are placed at the place and place are placed at the place and place are placed at the placed a										
To with	29b. Signature and title of certi	and manner stat	tea,	29c. Licens	se number		29d. Date signed (N	fonth, Day, Year)		
K	SICH	M		O.C.	M.E.		June 27, 2007			
10/2	30. Name and address of person Susan Hogan MD.	on who come kited cause Assistant Medical		enn Street, Balt	timore. MD 21	201				
State	31. Date filed (Month, Day, Year	r) 32. egi	istrar's Signature							
Registra	III A	9 2007	we & A	and _						
DHMH 17 Rev 1/2001		•	ORIGIN	IAL						

	-			er	a
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland	Department of Health and Mental Hygiene.	Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show	any Injury or other traumatic event, the Medical Examiner must be notified at	9300

**Physician** /Medical Examiner

The law requires that the death certificate be executed ng physician and as the burial-trans nding physician use for detached the pe e page certificate or Attending Physician: this funeral After within 24 hours after death.

To the Funeral Director: completely filled in by the f

Division or Vital Records,

the

2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 18,2007 8:40pM Magdala June Marie Johnson /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 14739 Chisholm Landing Way Montgomery Gaithersburg 8. Date of Birth (Month, Day, Year) 12/06/1962 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Days 1 □ M 2 🖫 F Months Hours 216-15-0442 44 Gambia Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a State MD Montgomery Gaithersburg 1 ☐ Yes 2 XNo 10f. Zip Code 10g. Citizen of What Country? 14739 Chisholm Landing Way 20878 Gambia by Funeral 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: Specify. Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Accountant Automotive 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thomas Nathaniel Johnson Emeline Ida Savage 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cod 20878 Herbert Johnson/Husband 14739 Chisholm Landing Way Gaithersburg, Md 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Remoyel from State Gate of Heaven 6/23/2007 Silver Spring, Md 4 ☐ Donation / 5 ☐ Other (Specify) 21. Signature uneral Service Licen PHILIPADS RIWALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) metastases Brain ACUTE Due to (or as a consequence of): Breast cancel metastahc Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): by Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year 4 ☐ Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy perform 28 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient P 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending 1 X Natural investigation 1 □ Yes 2 □ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1X Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) 9707 Moclial 112/2/5

State Registrar strar's Signature

10D526

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Department of Health and  State of Maryland / Department of Health and  Certificate of Death	Mental		ene g. No. 🤈 🏻	107	21643		
My.	Physicia	an l	1. Decedent's Name (First, Middle, Last)	2. Date Mont	of Death		Year	3. Time of Death		
-3ml (Sc.	/Medic	al .	Andrew John Jastrab  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death			16,	2007 ty of Death	5:26p <sup>M</sup>		
	Examin	er	Anne Arundel Medical Center Annapolis					Arundel		
	Funeral Director		5. Social Security Number 178–32–4406 6. Sex 17. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hr Months Days Hours Min	8. Date (Mon Aug.	of Birth th, Day, 1	1941	9. Birthp Cour Penr	lace (State or Foreign try) isylvania		
	yland now at		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits					
J36  In after death was after items 23a in aminer must items	Director	MD Anne Arundel Arnold  10e. Street and Number 10f. Zip Code		100	a Citizen of	f What Cour	1 □ Yes 2 No			
	ral Dir	449 Century Vista Drive 21012			US	SA				
	To Be Completed by Funeral	11. Marital Status  1 □ Never Married 2 ▼ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 ▼ Yes 2 □ No If Yes, Give Year or Dates:  12. Was Decedent Ever in U.S. Armed Forces?  1 ▼ Yes 2 □ No Specify:  13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Put Yes, Give 1959—  1 □ Yes 2 ▼ No Specify:	(Specify Yes erto Rican, et	or No- c.)	BI	ace - Americ ack, White, lify: Whi	etc.			
2121 ed within giene. er than "		15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	vorking	S	ocial	Secur	ity			
		5 Computer Administra  17. Father's Name (First, Middle, Last) 18. Mother's N				strati	on			
ire, Maryland s 1 and 2 should be fil if Health and Mental H them 27 Is marked out other traumatic even		7777 42.47. 4.12.47. (1.12.	lia Kl		arderi odini	imey				
		19a. Informant's Name/Relationship (Type. Print)  Lynn Jastrab/Wife  19b. Mailing Address (Street and Number or 449 Century Vista I				n, State, Zip MD 21				
	of te		4□Donation 55□Other (Specify)   Metro Crematory 20	ne 20,			n - City or To			
Balt	permit. Page Department of Important: If any Injury or once.		21. Signature of Extremal Service V census 22. Name and Address of Facility Rarranco & Sons, I 495 Gov. Ritchie	P.A.	Seve:	rna Pa	ark Fu	neralHome D 21146		
0000			23a. Tart1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. Listory one cause on each line.  Approximate Interval Between Operating Death							
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12	Examiner		insease or or indition resulting in death)  a. Shewic of the condition							
ted sit			Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury							
.09	ficate be executed physician and s the burial-transit	al Examiner	that initiated events resulting in death) Last Due to (or as a consequence of):							
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ecords, law requires the state of the state of the signer of the state	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown  25c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 5 □ Other (specify) □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □			23d. Date of delivery Month Day Year					
	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	236	23e. Did tobacco use contribute to the cause of death?  12 Yes 2 No 3 Probably 4 Unknown						
	Completed						Vas an utopsy findings available prior to completion of cause of death?  ss 2 □ No 1 □ Yes 2 □ No			
Viital	Iclan: Sertifica ector, p	Be	25. Was case referred to medical examiner?  Hospital:  Other:							
on or Vital Reding Physician: The International After this certificate he funeral director, page	بر 1	1 Yes 2 No 1 Indeptient 2 ER/Outpatient 3 DOA Other 4 Nursing Home 5 Residence 6 Other (Specify)								
Division or Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, p Medical Certification: To Be C			1							
	To th within To th comp	Me	29b. Signature and the of certifier 29c. License number	4	29	d. Date sig	ned (Month,	Day, Year)		
	(XX)	٢	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		(	06 (	16/	07		
	15th		Stephen Olexo AAMC.			** ** **				
	Sta Regist		Stefuen Olexo AAMC.  31. Date filed (Month, Day, Year)  JUN 2 0 2007  JUN 2 0 2007							

DHMH 17 Rev 1/2001

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07-04612 State of Maryland / Department of Health and Mental Hygiene Sterling C. Klischer Certificate of Death 1- For State Reg. No Registrar

1. Decedent's Name (First, Middle,Last) 3. Time of Death 2. Date of Death Physician/ 2224 hrs June 16, 2007 Sterling Chace Klischer **Medical Examiner** c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Cheverly Prince George's Hospital If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Numbe 7. Age (In yrs. last birthday) **Funeral** Months Davs Hours 1959 Country) Maryland Director June 15, 48 212**-**68**-**7101 1 X M 2 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 Yes 2 X No or 28a-f show s 23a or 28a-f show e notified at once, Elkridge Maryland Howard rector 10g. Citizen of What Country 10e. Street and Number United States ā 6665 Aspern Drive 21075 14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status event, the Medical Examiner must be or items If Yes, specify Cuban. Mexican. Puerto Rican. etc.) Armed Forces' 2 Never Married 2 X No Yes Yes 2 X No specify. Specify White 4 X Divorced If Yes. Give Year Widowed "natural", 2 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) more, MD 21215-0036
Pages 1 and 2 should be filed within 72 hent of Health and Mental Hygiene. Washington Sanitation Comm Development Service Technician 12 If item 27 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ortha Gilmore George A. Klischer Jr. Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print ) 11206 Dorset Lane, Beltsville, MD Ortha G. Klischer, Mother 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date 20a. Method of Disposition Baltimore, crematory or other place) other 1 X Burial 2 Cremation 3 Removal from State June 23, 2007 West Chester, PA hent crant: Greenmount Cemetery 9 Donation 5 Other Specify: 22. Name and Address of Facility Tonald V. Borowardt Funeral Home, P.A. 4400 Powder Mill Road, Beltsville, Maryland ignature of Funeral Service Licensee 20705 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval **Physician** Between Onset and Medical Death Multiple Injuries Immediate Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical AMENDED UNPENDED attending physician or use as the burial The law requires that the death certificate be Box 68760, 23d Date of delivery 23c. If yes, outcome of pregnancy IE FEMALE 23b. Was decedent pregnant in the Day Year Month Live birth 3 Ectopic pregnancy Fetal death past 12 months Pregnant at time of death 5 Other (Specify) signed by the atte 1 Yes 2 No 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 1 Yes 2 ✔ No 3 Probably 4 Unknown ð Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy has performed' death? ✓ Yes Yes 2 No this certificate 26.Place of Death (Check only one) 25. Was case referred to medica Be examiner? Hospital: 1 Other<sub>4</sub> Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ို 1 🗸 Yes 28d. Describe how injury occurred After t 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury 27. Manner of Death Operator of motorcycle which struck a truck Certification: Jun 16, 2007 1 1840 hrs Natural Yes 2 ✔ No Pending 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide or Town, State) N/B MD 261, Huntingtown MD determined (Specify) Roadway 4 Homicide

To the Hospital or Attending Physician: within 24 hours after death. Division of Vital To the I

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number and/title of certifier 29b. Signatur

dress of person who completed cause of death (Item 23a) Mary G Ripple MD Deputy Chief Medical Examiner

111 Penn Street, Baltimore, MD 21201

O.C.M.E.

31. Date filed (Month, Day State Registrar

**ORIGINAL** 

Medical

OCME

June 17, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JYTY 1, 2007 10:53 PM<sub>M</sub> **Physician** Genevieve Loretta Lohr /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Northampton Manor Nursing Home Frederick Frederick If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 M M XX 218-09-6594 90 1916 Washington. Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits iral", or items 23a or 28a-f shov Examiner must be notifled at Maryland Frederick 1 ☐ Yes 2 No Frederick Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important! if item 27 is marked other than "natural", or items 23a or any hiury or other traumatic event, the Medical Examiner must be a 8527 Reich's Ford Road 21704 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 Molo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: White Be Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Analyst US Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Loretta Genevieve McQuien John Albert Martin 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 8527 Reich's Ford Road, Frederick, MD 21704 Marvin E. Lohr, Jr., son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Smithsburg Crematory July 3, 2007 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Smithsburg, MD 4 □ Donation 5 □ Other (Specify) Reeney and Basford PA Funeral Home 106 East Church St., Frederick, MD 21. Signature of Funeral Service Licensee Richas MO0255 21701 that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrests on each line Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cau Immediate Cause (Final Physician disease disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last . Box 68760 Ly Date to for as a consequence of: Examiner and il-transit law requires that the death certificate be execu ng physician ar as the burial-to Due to (or as a consequence of) Physician/Medical attending p IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day 5 ☐ Other (specify) P.O. as been signed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 🗌 Yes 2 No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No page 2 No certificate 1 ☐ Yes or Vital Yes Physiclan: funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' 1 Yes 2 No Other: 2 1 Inpatient 2 ER/Outpatient 4 Nursing Home 5 Residence 6 Other (Specify) 3□ DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Division To the Hospital or Attending (Month, Day Year) 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the f 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD. July 2, 2007 8 Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

			1 - For State Registrar	State	of Marylai			ent of H		d Me		giene 1eg. No.	20	07	2164
	Dhamiri		1. Decedent's Name (First, Middle	, Last)							Date of Dea	Day	Ve	ar	3. Time of Death
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. 100	Examir		4a. Facility Name (If not institution,		umber)		4b. Ci		Location of De				County of I		
			Holy Cross H		T=		16 1 100		er Spri				ontgo		
	Funeral Director		5. Social Security Number 164-22-1064	6. Sex 1 □ M 2 💢 F	7. Age (In yrs 80		Month	der 1 Year Days		in.	Date of Birti (Month, Day eD. 24	Year	27	Count Pen	ace (State or Foreign ry) nsylvania
			Usual Residence of Decedent								CD. 24	, 10	2/	1 011	iloy I valita
	nylan how		10a. State 10b. County		10c. C	ity, Town or Lo	cation							10	d. Inside City Limits
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36	itied within 72 hours after death with the Maryland Hygiene. ither then "naturel", or itema 23a or 28a-f ehow inti, the Mexical Examinar must be notified at	by F	1 ☐ Never Married 2 ☐ Marrie 3 🕅 Widowed 4 ☐ Divorced	lf Yes, € Year or			1 🗆 Yes	2 <b>∑</b> No	Specify:				Specify:	Whi	te
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Maryland	12 sh h and 7 le m treum		19a. Informant's Name/Relationsh		Com				and Number or						
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	15		30. Name and address of person w												
			Dr. Maria D'Arl				Roa	ed, Si	lver Sp	orin	ıg, Mar	ylar	nd 209	910	
9	Sta Registr		31. Date filed (Month, Day, Year)	2007	Registrar's Sign		1-1	ob a							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2007 JUNE 18, **Physician** 1:15 PM ROBERT ESTILL LA FORCE, JR. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ANNAPOLIS ANNE ARUNDEL ANNE ARUNDEL MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1**X** M 2□ F 078-12-4325 88 Director JUNE 29, 1918 MISSOURI Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f show r must be notifled at 1 Yes 2 □ No Director MARYLAND ANNE ARUNDEL ANNAPOLIS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1108 AUGUST DRIVE 21403 UNITED STATES Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1XYes 2 No If Yes, Give 194 Year or Dates. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married ō Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 ☐ Divorced WHITE "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) the AIRLINES AIRLINE EXECUTIVE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) DOROTHY GEORGEN ROBERT ESTILL LA FORCE, SR. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1117 PRIMROSE COURT, #303, ANNAPOLIS, MARYLAND 21403 PETER B. LA FORCE/SON of Health 27 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: if It any Injury or c once. 1 ☐ Burial 2 ▼ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION JUNE 19 2007 STEVENSVILLE, MARYLAND CENTER 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM CREMATION AND FUNERAL CARE, 21401, 814 BESIGATE ROAD, ANNAPOLIS, MARYLAND 21401, 21. Signature of Funeral Service Licensee Will Etous M00672 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Due (or as a consequence of) disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cauce. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician a s the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed death? 1 ☐ Yes 2 No 1□ Yes 2**20**No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No P 1 Minpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Certification: 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 2 ☐ Accident 5 Pending investigation Injury ours after death. 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Division or Vital Records, P.O. Box 68760,

Registrar

31. Date filed (Month, Day, Year) JUN 1 9 2007

Wood



MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Frint)

M10057635

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 06 Physician 2007 0945 FRANCES **MYERS** /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ALLEGANY CUMBERLAND MEMORIAL HOSPITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours Jan 31, County 1 M 2 F 80 213-22-2685 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Cumberland Allegany 1X Yes 2 No MD Director 10g. Citizen of What Country? 10e. Street and Number 21502 USA 220 Somerville Avenue Apt 613 Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: white Specify. 3altimore, Maryland 21215-0036 þ 3 K Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Footers Cleaners laborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ( Charlotte Lowther Schade Carl Henry Schade 19b. Mailing Address (Street and Number or Bural, Route Number, City or Town, State, Zin Code 21502 14221 Walter Drive SW Cumberland 19a. Informant's Name/Relationship (Type. Print)
Nancy Snyder daughter 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Sunset Memorial Park 6/29/2007 MD 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Cumberland 22. Name Scarbell Function Home, PA
108 Virginia Avenue: Cumberland,
23a. In Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line.

Immerite Cause (Final disease or condition resulting in death) 4 ☐ Donation 5 ☐ Other (Specify) 108 Virginia Avenue: Cumberland, MD 21502 Approximate Interval Between Onset and Death **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the attending physician and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown been signed by the should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>≽</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy performe 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28b. Time of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

9 Medical Examiner: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie D36766 June 28,2007

Registrar DHMH 17 Rev 1/2001

State

u

30. Name and address of person

31. Date filed (Month, Day, Year)

UMBURLAND MI)

who completed cause of death (Item 23a) (Type, Print)

istrar's Signature

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			For State ZANA	END#2,perM					partme <i>ertifica</i>		lealth and N Death	lental Hy	gien Reg. No	0000	2161.0
			Registrar L'     Decedent's Nam			UI,DES	,1300		Cramoa	10 01 1	Death	2. Date of De	eatijun	e 14,2007	3. Time of Death
	Physicia /Medic		Car	men Madri	1							Month <del>June</del>	15	Year 2007	3:25 p M
	Examin		4a. Facility Name (	If not institution,	give street a	nd number)			4b. City	y, Town, o	r Location of Death		40	c. County of Deatl	1
-			5. Social Security N	Casey Ho	. Sex	7 Ag	e (In yrs. i	ast hirthd	av) If Und	er 1 Year	ockville If Under 24 Hrs.	8. Date of Bi	rth	Montgom 9. Birth	ery  pplace (State or Foreign
	Funeral Director		578-42-32		1 M 2		80	Yrs	Months		Hours Min.	(Month, D April 8,	ay, Year	) Cos	intry) ington, D.C.
1			Usual Residence o				10c City	, Town or	Location						10d, Inside City Limits
	faryla shov	ō	10a. State  Maryland	10b. County  Montgot	m <b>A 2</b> 37		100. 01.	, 10111101		er Sp:	rino				1 □Yes 2 No
	r 28a-	Funeral Director	10e. Street and Nu		nery					ip Code			10g. C	itizen of What Co	untry?
	th with	al D	9039	Sligo Cr	eek Par	kway #4	16				20901			U.S.A	
	tems	nue	11. Marital Status		Arn	s Decedent ned Forces?		S. 1	<ol><li>Was Dec if Yes, sp</li></ol>	edent of H ecify Cub	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or N Rican, etc.)	0-	14. Race - Amer Black, White	
20	irs afte	by F	1 ☑ Never Mar 3 ☐ Widowed	ried 2  Marrie 4  Divorced	If Y	]Yes 2∭∏l es, Give ar or Dates:	NO		1 ☐ Yes	2 <b>⊠</b> No	Specify:			Specify:	White
2-003p	72 hou natura lical E		/Sne	15. Decedent's	Education	leted)		16a. De	cedent's Us	ual Occup	nation during most of work	kina	16b.	Kind of Business/I	ndustry
V	ne. han "ı e Med	Completed	Elementary/Sec		·	lege (1-4or 5	5+)	`lit			during most of work d)	9		7 مم 1 م	ines
N	filed v Hygie Ither t		12 17. Father's Name	(First, Middle, La	ast)				11(	cket A	18. Mother's Nam	e (First, Middle	e, Maide		Tiles
yland	ild be fental rked o	To Be	Faust	o Madrid							Се	cilia Ke	rshaw		
Mary	2 shou and N Is mai		19a. Informant's N	lame/Relationship	(Type. Pri	nt)		19b. M	ailing Addre	ss (Street	and Number or Ru	ral Route Num	ber, City	or Town, State, 2	lip Code)
≥ m̂	l and lealth im 27 her tr			irtz - Cou	sin		20h P				ngs Road, F	rederick Date	· -	yland 217 Location - City or	
	ages int of H	,		☐Cremation 3		I from State			sposition (N crematory o		1				
Бапптоге,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of F	5 ☐ Other (Special Service L	$\overline{}$	1	Gai	te of		and Addre	ess of Facility			ver spring	, Maryland
ă	permi Depar Impor any Ir		ton	a KX	Leu	No	<u></u>		Hines-F 11800 N	Rinald New Ha	i Funeral H mpshire Ave	ome, Inc nue, Sil	ver S	pring, Mar	yland 20904
			shock or he	art failure. List o	omplications nly one caus	s that caused se on each li	d the death ne.	n. Do not	enter the m	ode of dyir	ng, such as cardiac	or respiratory	arrest,		Approximate Interval Between Onset and Death
1	Physician /Medical		Immediate Cause disease or conditi- resulting in death)	on	a	oue to (or as	Pneumo								
	Examiner				ľ., '	de lo (or as	a consequ	uence on).							
	p #	ner	Sequentially list of if any, leading to i cause. Enter Und	eriving	D	Due to (or as	a conseq	uence of):							
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68/60,	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	_				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	a 551155 4								
	tificate ng phy: as the	Physician/Medica			u										
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Ţ	requires that the een signed by th hould be detache	by Ph	Part II. Other sign	ificant condition	s contributi	ng to death b	out not res	ulting in th	e underlying	g cause giv	ven in Part I.	23e. Did	tobacco	use contribute to	the cause of death?
Spuc	equire en sig ould b											1	] Yes	2 No 3 Pr	obably 4X Unknown
ecord	e law r has be e 2 sh	Completed										24a. Wa	s an opsy formed?	prior to	itopsy findings available completion of cause of
E E	ician: The law certificate has I rector, page 2 s		05 Management	and to modical							00 81	1□ Yes	2 <b>X</b> N	lo 1 ☐ Yes	2□ No
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n o	ding Phys n. After this funeral di		27. Manner of Dea	ath 5 ∐Pending		. Date of Inju	ury ay Year)	28b. Tim Inju		28c. Inju Wo		28d. Describe			
<u>0</u>	Attending r death. ector: After by the funer	catic	2 Accident	investiga 6 ☐ Could no	tion	Diago of in	iume At he	me form	M street foot		]Yes 2□No	29f Location	/Ctroot	and Number or D	ural Route Number,
UIVISION	l or At after d Direc	Certification:	4 ☐ Homicide	al ada sussis		. Place of in building, e	tc. (Specif	y)	, street, lact	ory, office		City or T	own, Sta	and Number of Hi ate)	urai noute Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu		29a. Certifier (Check only								ime, date and place opinion, death occu				
	the Hi hin 24 the Fi mplete	Medical	one)			nd manner st					se number			Date signed (Mont	
<b>\</b>	Viti Cor		29b. Signature an	use W	20/16	Bust	= W	60			6461	5		-	,
7	6		30. Name and add	- (	ho complete	ed cause of	death (Iten	n 23a) (Ty					Ju	ine 18, 200	01
			Gener	vieve Wrob		M.D.,	6001	Muncas		11 Roa	d, Rockvill	e, Maryl	and 2	20855	
	Sta Registi		31. Date filed (Mo	JUN 2 0	2007	32. Regist			Coart						
	negisti	aı		D M LINE	FOOI	A STATE OF THE STA	100	N.	CARRIED LA						

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

ulianna Elizabeti		State of Maryland / Department 1- For State Certificate Registrar			. No. 000	
Physiciar Medical Examin	n/	1. Decedent's Name (First, Middle,Last)		2. Date of Death Month I June 21, 20		3/Time of Death \ \
neulcai Examini		Julianna Elizabeth Maurel  4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Deal		4c. County of Death	
	4	500 Washburn Avenue 2nd floor 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Baltimore  If Under 1 Year   If Under 24Hi	re 8 Date of Birth	(MM/DD/YYYY) 9. Bir	thplace (State or
Funeral Director		621-18-7334 1_M 2EXF 34	Yrs. Months Days Hours Mi		Foreig	
any	ļ-	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Lo	cation			10d. Inside City Limits
Maryland 28a-f show d at once.	į	MD Baltimo:	re 10f. Zip Code	110	g. Citizen of What Cou	1 <sub>XX</sub> Yes 2 No
5-0036 cd within 72 hours after death with the Maryland tygiene. other than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at once	Director	421 Baltimore St.	21202	10	USA	,
ith with tems 23 st be no	Funeral	4 Valorian Marrian 0 Marrian Armed Forces?	Was Decedent of Hispanic Origin? ( \$ If Yes, specify Cuban, Mexican, Puerl		14. Race - Amer White, etc.	ican Indian, Black,
ifter des	- 1	1 Yes 2 <sup>X</sup> No	Yes 2 X No specify:		Specify:	Vhite
hours a	ted by	15. Decedent's Education (Specify only highest grade completed) 16a. Dece	dent's Usual Occupation (Give kind of g most of working life. DO NOT use re		16b. Kind of Business/	Industry
5-0036 led within 72 hours: Hygiene. Other than "natur:	Completed	12	Dancer		Thea	ter
21215-0036 uld be filed within 7 Mental Hygiene. marked other than cevent, the Medica	Be Co	17. Father's Name (First, Middle, Last) Arthur A. Maure1		ne (First, Middle, Ma a MacDona		
□ sh as in the last in the la			iling Address (Street and Number of 1 43rd St. South	Rural Route Numb	per, City or Town, State	7366
ore, M s 1 and 2 of Heath If item 21	ŀ		position (Name of cemetery, r other place)	Date	20c. Location - City or	Town, State
Baltimore, I permit. Pages I and Department of Heath Important: If item injury or other tra		4 Donation 5 Other Specify: Metro Cre			Baltimore	
Ball permit Depart Impor		12 . / 1 / 7 1	<ol> <li>Name and Address of Facility Ha</li> <li>Ridgely Ave. A</li> </ol>	-		e, P.A.
Physician /Wedicar		23a. Part I. Enter the disease, Complications that caused the death. Do not ent failure. List only one cause on each line.				Approximate Interval Between Onset and
Examiner	ĺ	Immediate Cause (Final disease or condition resulting in death)  a. Narcotic (morphine) and Due to (or as a consequence of):	alcohol intoxication			Death
		Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):				
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	11 117			
outed nd transit	Exa	events resulting in death) Last				
60, ate be executed physician and te burial - transit	edica	X UNPENDED AMENDED 27,28a-f, perME,	g869, 7/6/07 TT			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	an/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2	Fetal death 3 Ectopic preg	nancy	23d. Date of deliver Month	Day Year
Box 687 death certific: the attending p	ysici	1 Yes 2 No 9 Unknown 9 Unknown	Other (Specify)		0.00	
that the d	by Ph	Part II. Other significant conditions contributing to death but not resulting in the	he underlying cause given in Part I.	23e. Did tot	pacco use contribute to	the cause of death?
Division of Vital Records, P.O. tal or Attending Physician: The law requires that th rs after death.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach				24a. Was a	n 24b. Were a	utopsy findings available
ecor ne law n te has b	Completed			autops perforr  1 ✓ Yes 2	med? death?	completion of cause of es 2 No
Vital Rec ysician: The his certificate director, page	Bec	25. Was case referred to medical examiner?	26.Place of Death (Chec	k only one)		become!
n of Vit ding Physic After this of	의	1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpat  27. Manner of Death 28a. Date of Injury (Month, Day, Year)  28b. Time			Residence 6  Othe	er: Scene
ion c tending eath. for: Af	ation	Natural 5 Pending	:30 pm 1 Yes 2 X No	unk		
Division To the Hospital or Attent within 24 hours after death To the Funeral Director:	Certification:	3 Suicide 6 X Could not be determined (Specific)		or Town, St	ate)	ural Route Number, City
Hospital 24 hours Funeral tely fille		29a. Certifying Physician: To the best of my knowledge, death or	ccurred at the time, date and place, a	nd due to the cause	e(s) and manner as sta	Fl Baltimore. M
To the Hos within 24 h	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigand manner stated.		d at the time, date a		
6.	2	29b. Signature and title of certifier	29c. License number O.C.M.E.		29d. Date signed (Ma June 22, 2007	onur, Day, rear)
100g		30. Name and address of person who completed cause of death (Item 23a)				
.7/2			n Street, Baltimore, MD 212	01		
Sta Registi	rar	31. Date filed (Month, Day Year) 2 9 2007 32. Refistrar's Signature	grande .			
DHMH 17 Rev 1/20	01	ORIGI	NAL			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 17 pay Month Physician John Joseph McGovern, Sr. 2007 6:00 pM June /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel 931 Edgewood Road Apt. 218 Annapolis 8. Date of Birth (Month, Day, Year) 5, 1921 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1⊠M 2□F 087-16-2565 New Hampshire **Director** Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 X Yes 2 □ No Directo MD Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 931 Edgewood Road 21403 Apt. 218 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White þ 3 Widowed 4 ☐ Divorced WW II Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Attornev Legal 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James F. McGovern Margaret Healy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Terry McGovern/Son 655 White Swan Drive Arnold, MD 21012 June 23, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cem. 4 ☐ Donation \_ 5 ☐ Other (Specify) Silver Spring, MD 2007 22. Name and Address of Facility
Barranco & Sons, P.A.
495 Gov. Ritchie Hwy. 21. Signature of Funeral Septice Ligenses Severna Park Funeral Home Severna Park, MD 21146 lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Enter the diseas mmediate Cause (Final disease or condition resulting in death) Infarction Myocard Physician Minutes /Medical Due to (of as a consequence of): **Examiner** Septientially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): ig physician and as the burial-transit death certificate be executed Exami Due to (or as a consequence of): Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) signed by the a ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 Ho 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has le 2 page performed? certificate 1 Yes 2 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28d. Describe how injury occurred After 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

P.O. Box 68760, Division or Vital Records,

To the Hospital or Attending Physician: Certification: within 24 hours after death To the Funeral Director: completely filled in by the Medical

State Registrar 29a, Certifier

(Check only one)

29b. Signature and title of dertifier

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

Hwy Arnold, MD 21012

6-18-2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Chaconas James

1509

31. Date filed (Month, Day, Year)

JUN 2 0 2007



07-04	856
Eboni	McGinty

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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,		1- For State Criticate of Death Registrar Certificate of Death	Reg.	No.	
Physici Medical Exam	an/	1. Decedent's Name (First, Middle,Last)	2. Date of Death Month D	ay Year	3. Time of Death 0644 hrs
wedicai Exam	mer	Eboni Javana McGinty  4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death	June 26, 200	4c. County of Death	
( )		508 Short Curve Road Glen Burnie		Anne Arundel	
Funeral Director		428-59-7384 1 M XXF 22 Yrs. Months Days Hours Min.	8. Date of Birth(	MM/DD/YYYY) 9. Bir Foreig 1985	
ow any		Usual Residence of Decedent  10a. State  10b. County  MD  Anne Arundel  10c. City, Town or Location  Glen Burnie	7		10d. Inside City Limits  1 Yes 2 X No
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 508 Short Curve Rd. 10f. Zip Code 21061	10g.	Citizen of What Cour	ntry?
death with ir items 23s	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 1 X Never Married 2 Married Armed Forces? 1 Yes 2 X No		14. Race - Ameri White, etc.	can Indian, Black,
ours after tural", o	d by F	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: or Dates:  15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of wo		Specify: B	lack ndustry
)36 thin 72 ho re. than "ns edical Es	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)  College (1-4 or 5+)  Student Worker	ed)	Daycare	
215-0( e filed wi tal Hygier ked other nt, the M	Be Cor	17. Father's Name (First, Middle, Last)  Gregory McGinty  Hattie	First, Middle, Mai	,	_
D 212 should b and Men 7 is marl	ToE	19a. Informant's Name/Relationship (Type, Print)  Hattie McGinty Mother  19b. Mailing Address (Street and Number or Relationship (Type, Print))  508 Short Curve Rd. G.	ural Route Numbe	er, City or Town, State	
ore, M ss I and 2 of Health If item 2		20a. Method of Disposition  1	Date 2	Oc. Location - City or	
altimo mit. Page partment e portant: ury or otl		4 Donation 3 Other Specify.		Canton, Mi	
		21 Signature of Funeral Service Licensee  22. Name and Address of Facility Hard Annapolis, MD 2140			
Physician /Medical caminer		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Seizure disorder complicated by hypertrophic cardinal death)  Due to (or as a consequence of):			Approximate Interval Between Onset and Death
	ēr	Sequentially list conditions, if any, leading to immediate  b.  Due to (or as a consequence of):			
ted 1 ansit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  c.  Due to (or as a consequence of):  d.			
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3760, ficate be g physicis the burning		IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the	ncv.	23d. Date of deliver	/ Day Year
Box 68' e death certiff the attending ed for use as	ysician/	past 12 months?  1  Yes 2 No 9 ✓ Unknown  1  Uve birth 2 Fetal death 3  Ectopic pregnant at time of death 5  Other (Specify) 9  Unknown		NOTAL C	ody Tour
i, P.O. Bc ires that the des signed by the a	by Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		cco use contribute to	the cause of death?
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Completed		24a. Was an autopsy performe	prior to death?	topsy findings available completion of cause of
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Vit Physici r this c al dire	To E	( V Tes Z No	,	esidence 6 🗸 Other	r: Scene
ion of tending leath. tor: Afte		27. Manner of Death  1 X Natural 5 Pending 2 Accident Investigation  28a. Date of Injury (Month, Day, Year)  28b. Time of Injury 28c. Injury at Work?  1 Yes 2 No	28d. Describe how	v injury occurred	
Divis nital or At urs after d eral Direc	Certification:		28f. Location (Stre or Town, Stat		ral Route Number, City
Division of Northe Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After to completely filled in by the funeral	Medical C	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and conserved at the time, date and the time			
E S F OS	Me	29b. Signature and title of certifier  29c. License number  O.C.M.E.		9d. Date signed <i>(Mo</i> ) June 27, 2007	nth, Day,Year)
a du	7	30. Name and address of person who completed cause of death (Item 23a)			
2/2		Tasha Greenberg MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD  31. Date filed (Month, Pax Year) 2 2007 32. Resistrar's Signature	21201		
S Regis	tate trar	31. Date filed (Month, Park Sear) 9 2007 32. Resistrar's Signature			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Da Month Physician Ruth Evelyn Nevils June 17, 2007 P M 3:45 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Casey House-Montgomery Hospice Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Dec 31, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1□M 2**⊠**F 578-24-1541 99 1907 Washington, DC Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r 28a-f show notified at Maryland Montgomery Silver Spring 1 □Yes 2KNO Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? тs 23a or ? must be п 1220 Millgrove Road 20905 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian "natural", or Items dical Examiner πι 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed by 3 X Widowed 4 ☐ Divorced White permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Federal Elementary/Secondary (0-12) 10 College (1-4or 5+) Supervisor Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert Wright Marshall Florence Gertrude Howard ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4516 Bennion Road, Silver Spring, Maryland 20906 Harry Young (Son) 20b. Place of Disposition (Name of Park Fawn) Menior Tare)
Park
Park 20c. Location - City or Town, State 20a. Method of Disposition June 21. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 2007 4 ☐ Donation 5 ☐ Other / Specific Rockville, Maryland 21. Signature of Funeral Service 22. Name and Address of Facility DeVol Funeral Home, 10 E. Deer Park Drive, Gaithersburg, MD 20877 23a. Part. Her he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sho k, in least failure. List only one cause on each line.

Immediate the second condition resulting in death)

a. Congressive Heart Failure

Due to or as a consequence of: Approximate Interval Between Onset and Death **Physician** /Medical Due to or as a consequence of) Examiner Coronary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Lines of derigning Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed the burial-tran Due to (or as a consequence of) physician Physician/Medical use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 5 Other (specify) ned by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? been signe should be d Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown 24a. Was an autopsy performe Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No page 2 s this certificate 1∐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospice 1 ☐ Yes 2 录No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Iniury 1 KN Natural 5 Pending investigation

Division or Vital Records, P.O. Box 68760, or Attending Physician: After death.

funeral ours after death.

neral Director: A
filled in by the fu To the Hospital o within 24 hours aft To the Funeral Di

Medical Certification: To 1 🖰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00064615 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Genevieve Wroblewski, M.D. 1355 Piccard Drive, Suite 100, Rockville, MD 20850

State Registrar

31. Date filed (Month, Day, Year) JUN 2 0 2007

6 Could not be determined

2 ☐ Accident

3 ☐ Suicide

4 Homicide

32. Pagistrar's Signature

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

June 18, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** /Medical 4a. Facility Name (If not institution, give street and number 4c. County of Death 4b. City, Town, or Location of Death Examiner Coastel elisbu LUICOMILO 67 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number Date of Birth (Month, Day, Year) 7. Age (In yrs, last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 1 F Director 90 1/5/1917 Maryland 215-12-6744 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If Item 27 is marked other than "natural", or Items 23a or 28a-1 show any Injury or other traumatic event, the Medical Examiner must be notifiled at 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County 1 ☐ Yes 2 🛣 No Director Maryland Wicomico Salisbury 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3652 St. Lukes Road 21804 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ★No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify: white ð 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Archibald Johnson Lula Hitch 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Wayne G. Nuse/son PO Box 267, Fruitland, MD 21826 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Olivet Cemetery 6/18/07 4 Donation 5 ☐ Other (Specify) Eden, MD of Funeral Service Livense Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 29 . Part . Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line Do not enter the mode of dying, such as cardiac or respiratory arrest, Immeriate Cause (Final **Physician** CSTIN resulting in death) /Medical to (or as a consequence of) Examiner 1/10 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last to (or as a consequence of). Examine that the death certificate be executed burial-tra Due to (or as a consequence of) Box 68760. Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.0. ed by the a 9 Unknown signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. or Vital Records, 3 3 Probably 4 Unknown 1 Tyes Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s certificate 1□ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2/2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After or Attending (Month, Day Year) Natural Division Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident the Funeral Director: 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital within 24 hours To the Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

State

completed cause of death (Item 23a) (Type, Print)

NID

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death Day 2007 Month Physician Rosetta Toledo Solene Crenshaw O'Neal 9:18 P M June 15. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rexford Assistant Living Center Prince Georges Lanham If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🛣 F Months Director 003-03-2736 90 Oct. 18, 1916 Rives, Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show Examiner must be notified at 1√ Yes 2 No Director Prince Georges Lanham 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 23a or 9885 Greenbelt Rd. 20706 Funeral U.S. 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11 Marital Status Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any lailury or other traumatic event, the Medical Examiner once. 1 ☐ Yes 2 👿 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Black ģ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Roy Crenshaw Geneva Jenning 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) April Iman Davis, Granddaughter 12 Kennebec Ave. #Bl Takoma Park, MD 20912 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Dakland Cemetery June 23, 2007 Carbondale, IL 22. Name and Address of Facility McGuire Funeral Service, Inc. 21. Signature of Funeral Service Licenses Thompso Ind 7400 Georgia Ave., N.W. Washington, D.C. 20012 12 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequance of): ACUTE /Medical Examiner Due to (or as a consequence of): PERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Uncertaing Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): physician al s the burial-t Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 3 □Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown has been signed to should to DISCASE Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an CSTEDARDAR certificate ha autopsy performed 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director;
completely filled in by the 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 🗠 🚅 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only 2 medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) HD D55559 19. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

7525 GROBNINA

32. Registrar's Signature

MASURI

JUN 2 0 2007

31. Date filed (Month, Day, Year)

CENTER DRIVE # 316,

4 ROSEKBUT

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death June 19, 2007 Plack Helene J. 8:15 A M 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 3234 Powder Mill Rd. Prince George's Adelphi 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 2 □XF Months Days Hours Min 95 215-62-4383 November 19. 1911 Australia

10f. Zip Code

1 ☐ Yes 2 ☐ No

16a. Decedent's Usual Occupation

Homemaker

20783

(Give kind of work done during most of working life. DO NOT use retired)

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Specify.

10d. Inside City Limits

10g. Citizen of What Country?

14. Race - American Indian.

Specify: White

16b. Kind of Business/Industry

Own Home

U.S.A.

1 □Yes 2√□No

10c. City, Town or Location

Adelphi

**Funeral** Director filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatte event, the Medical Examiner must be notifited at any Injury or other traumatte event, the Medical Examiner must be notifited at Baltimore, Maryland 21215-0036

**Physician** 

Examiner

/Medical

1 - For State Registrar

10a. State

Maryland

11. Marital Status

10e. Street and Number

Director

Funeral

Completed by

Usual Residence of Decedent

10b. County

3234 Powder Mill Rd.

1 ☐ Never Married 2 ☐ Married

3 Widowed 4 □ Divorced

Elementary/Secondary (0-12) 12

Prince George's

15. Decedent's Education (Specify only highest grade completed)

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:

College (1-4or 5+)

Physician /Medical Examiner

burial-tran r use as the burial attending p signed by the aid be detached for cate has t page 2 s certificate To the Hospital or Attending Physician: within 24 hours after death. Within 24 hours after ucc..... A

To the Funeral Director: Aft

Division or Vital Records, P.O. Box 68760,

	Be	17. Father's Name (First, Middle, Last	)		18. Mo	ther's Name <i>(F</i>	irst, Middle, Maide	n Surname)						
	T0 E	Unknowr	1			Unk	mown							
		19a. Informant's Name/Relationship	Type. Print)	19b. Mailing Addre	ess (Street and Nun	mber or Rural F	Route Number, City	or Town, State, 2	Zip Code)					
4		Elisabeth P. Burke	, Daughter	9211 Dewl	berry Lan	e, Coll	ege Park	, Maryla	nd 20740					
d		20a. Method of Disposition		lace of Disposition (/	vame of or other place)	Date	20c. l	ocation - City or	Town, State					
		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	JHemoval from State	rge Washingt		June 21.	2007 Ad	elphi. M	arvland					
ej j	ш	21. Signature of Funeral Service Lice		22. Name	and Address of Fac	cility	Europe 1	Ilomo D	A .					
once.	1	Word O. B	newant	4468	and Address of Fac Id V. Bor Powder M	ill Roa	d, Belts	ville, M	D 20705					
		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death						Approximate Interval Between					
an	1	Immediate Cause (Final disease or condition	Alzheimer						Onset and Death					
al		resulting in death)	Due to (or as a consequ											
er														
হা	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ	uence of):										
	Examine	that initiated events	C											
	Ĕ	resulting in death) Last	Due to (or as a consequ	uence of):		-								
	ca		▲d											
	Med	LE FERMI E			-									
	Jug I	FEMALE:  15. Was decedent pregnant in the past 12 months?  1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy  23d. Date of delivery  1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy												
	sicia	in the past 12 months? 1 ☐ Yes 2 ☑ No	4☐Pregnant at time of de					Month	Day Year					
	Å.	9 □ Unknown												
	Completed by Physician/Medical	Part II. Other significant conditions	ontributing to death but not resu	ılting in the underlyin	g cause given in Par	rt I.		<b>37</b>	the cause of death?					
	ed						1 ☐ Yes	2. <b>ZN</b> o 3. □ Pr	obably 4 ∐Unknown					
	be						24a. Was an autopsy	24b. Were au	topsy findings available completion of cause of					
.	Com						performed? 1□ Yes Z□ N	death? o 1 ☐ Yes						
	Be (	25. Was case referred to medical examiner?			26. Pla	ace of Death (C	heck only one)							
	٥	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ E	ER/Outpatient 3	DOA Other: 4	Nursing Home	5 X Residence	6 □Other (Spec	cify)					
	ä	27. Mapper of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d	l. Describe how inju	ry occurred						
	äţi	2 ☐ Accident investigation	the second second	М	1 ☐ Yes 2	□No								
.	≝	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At hor building, etc. (Specify	me, farm, street, fact	ory, office	28f.	Location (Street a City or Town, State	nd Number or Ru	ıral Route Number,					
	Ö													
	Medical Certification:	(Check only 2 Medical Exa	nysician: To the best of my know miner: On the basis of examinat	wledge, death occurr tion and/or investigati	ed at the time, date	and place, and death occurred	I due to the cause(	s) and manner as	stated.					
.	Ved	One)	and manner stated.											
	2	29b. Signature/and title of certifie	2 m sola	,	29c. License numbe	er	29d. Da	ate signed (Monti	h, Day, Year)					
		egway of	1 Vally 1	$n \cdot n$	D002195	54		June 20,	2007					
		30. Name and address of person who		, , , , ,										
		Dr. Edward Mosle			, Bowie,	MD 207	21							
Sta istra		31. Date filed (Month, Day, Year)	32. Registrar's Signat	ture										
		AMIL W O T	Julies 1	I Japania	)									
1/20	01		*	ET.										

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician June 73, 2007 1:24a M Jean McEwan Parker /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Somerford Place Annapolis If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) Oct. 11, 1 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Months Hours 1□M 2XF 014-28-8293 74 1932 ΜΔ Director Usual Residence of Decedent filed within 72 hours after death with the Maryland r 28a-f show notified at 10c. City, Town or Location 10a. State 10b. County 10d, Inside City Limits MD Anne Arundel Arnold 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or 2 Examiner must be n USA 252 Pendleton Court Funeral 21012 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married "natural", or 1 ☐ Yes 2 🔀 No Specify: White þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Secretary Defense Contractor permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If item 27 is marked other i any Injury or other traumatic event, tt 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George McEwan Lois Horne 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edgar Parker/Husband 252 Pendleton Court, Arnold, MD 21012 Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition June 19 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory Baltimore, MD 4 Donation 5 Dother (Specify) 2007 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 21. Signature of Funeral Service Licensee Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due I/(o) as a consequence of): monT **Physician** /Medical Examiner emen la Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of) Physician/Medical the as attending IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant ed by the atter detached for u 3 Ectopic pregnancy in the past 12 months Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death ☐Yes 2 ☑ No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed' Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral. 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 🗓 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Division or Vital Records, P.O. Box 68760, Fo the

Baltimore, Maryland 21215-0036

State Registrar 29b. Signature and title of certifie

5 31. Date filed (Month, Pay, Year)

JUN 2 0 2007

erson who completed cause of death (Item 23a) (Type, Print

29c. License number

29d. Date signed (Month, Day, Year)

			Pleas	e Type or Prir						_	ible.	
		4	For State	State of Ma	aryland		rtment of F tificate of			0.7	7 (7 (7	
			Registrar  1. Decedent's Name (First, Middle,	( ast)		Cei	uncate of	Deaill	2. Date of Dea	teg. No.	JU7	3. Time of Death
Phys		n	WILLIA	ME.	ER	RYC	iemr		Month &	Day	U 7	0710 M
	edica mine		4a. Facility Name (If not institution,				4b. City, Town, o	r Location of Death	1		y of Death	
	6		Anne Arundel Me		er ge (In yrs. la	at hirthday)	A If Under 1 Year	nnapolis   If Under 24 Hrs.	R Date of Rid	Ar		rundel place (State or Foreign
Fune Direct		:	5. Social Security Number 216–36–9911  Usual Residence of Decedent	5. Sex 7. Ag	66	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Pay June 19	, Year 940	Penr	ntry) ntry) ntry) ntry)
Maryland f show			10a. State 10b. County	Arundel	10c. City,	, Town or Loc		polis				10d. Inside City Limits 1 ★★ es 2 □ No
with the 3a or 28a st be notif		ā	10e. Street and Number 100 Severn Avenu	ue, #304	1		10f. Zip Code	21403		10g. Citizen of	What Cou	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Initury or other traumatic event. the Medical Examiner must be notified at		by Funeral	11. Marital Status  1 □ Never Married 2 □ Married 3 □ Widowed 4 ☑ Divorced	12. Was Decedent Armed Forces? d 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:			Vas Decedent of H f Yes, specify Cub I ☐ Yes 2 No	lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- to Rican, etc.)	14. Ra Bla Speci	ack, White,	can Indian, etc. Vhite
2 hou latura			15. Decedent's (Specify only highest		1	16a. Deced	lent's Usual Occup	pation	rking	16b. Kind of E	Business/Ir	ndustry
ithin 7		Completed	Elementary/Secondary (0-12)	College (1-4or	5+)		Photograp	during most of word) her	Killy	ടപ്പി f	-emp]	Loved
iled w Hygier ther th			17. Father's Name (First, Middle, La	4 ast)			посодгар		ne (First, Middle,			Loyeu
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2 shoul and Milis mark		<del>-</del> 9-	19a. Informant's Name/Relationship Kimberly Perryo		tor			and Number or Ru enue, #30				
1 and Health Iem 27		Y-	20a. Method of Disposition	rear/daugn	20b. Pla	ace of Dispos	sition (Name of	T T	Date Date	20c. Location		
Pages Int: If ite			1 ☐ Burial 2 MaCremation 3 4 ☐ Donation 5 ☐ Other (Spe				natorý or other pla oln Crema	tory 6/2	20/2007	Brentwo	od, M	Maryland
permit. Departm	once.		21. Signulus Truneral Service Li	11	1/			ess of Facility <b>Jo</b>		_		
3 2 2 E	5		John !	- Mill	dr						olis,	, MD 21401
Physici			23a. Part1. Enter the disease, or conshock, or heart failure. List of Immediate Cause (Final disease or condition	omplications that cause nly one cause on each li	d the death ine.	. Do not ent	1-1-	ng, such as cardiac				Approximate Interval Between Onset and Death
/Medic Examin			resulting in death)	Due to (or as	a co sequ	ence of):			. 0			
p <sub>0</sub>		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to for as	a consequ	ance JI).						
e executed sian and urial-transit		Examiner	that initiated events resulting in death) Last	c. Due to (or as	a consequ	ence of):						
ate be ex hysician and the burial	5 .	_		d								
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely illed in by the funeral director, page 2 should be detached for use as the burial-transit		Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 ☐ Fetal	death 3	Ectopic pregnanc Other (specify)	у			ate of deliv	very Day Year
uires that the de signed by the a	3	2	Part II. Other significant condition	s contributing to death b	out not resu	Iting in the ur	nderlying cause giv	ven in Part I.	23e. Did to			the cause of death?
The law require to has been signed 2 should be	1	Completed								rm <b>ed</b> ?	Were aut prior to co death?	opsy findings available ompletion of cause of
hysician: The la		Be	25. Was case referred to medical examiner?				Lau		1 Yes ath (Check only o	ne)	TLI Tes	ZLINO
Physic this c		2	1 ☐ Yes 2 ☑ No 27. Manner of Death	Hospital: 1 N Inpati		ER/Outpatien 28b. Time of	1 3 DOA		lome 5 ☐ Resid			ify)
th.		igi	1 Natural 5 Pending 2 Accident investiga	(Month, Da	ay Year)	Injury	Wo	rk? ]Yes 2∐No	Zou. Describe i	low injury occi	nied	
after dea		Certification	3 Suicide 6 Could no 4 Homicide determin	ed Zoe. Place of III	jury - At hor tc. (Specify		eet, factory, office		28f. Location (8 City or Tox		nber or Rui	ral Route Number,
To the Hospital or Attending Ph Within 24 hours after death. To the Funeral Director: After th		Medical C		Physician: To the best xaminer: On the basis of and manners	of examinat							
To the To		Ĭ	29b. Signature and title of certifier	J 24-	) A	ales	29c. Licens	se number 2143	8	29d. Date sign		
15 (H			30 Name and address of person w	- a EXTAM	death (Item	23a) (Type,	Print) FENSE H	16HWAn	ANNARO	us M	) 21	401
Rec	Stat gistra	e ir	31. Date filed (Month, Day, Year)  JUN 1.9	2007 32. Figist	rar's Signat		book					
DUMIL 47 De												

07-04799	
John Rock	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Manyland / Department of Health and Mental Hygiene

Rock	State of Maryland / Department of Health and Mental Hy 1-For State Certificate of Death	7 1 1 1	7 2165
Physician	Registrar  1. Decedent's Name (First, Middle,Last)	Reg. No C  2. Date of Death  Month Day Year	3. Time of Death
ical Examine	John Delain	June 24, 2007	1400 hrs
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 1100 Cathedral Street  Baltimore	40. Gounty of Death	
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs.	I I I I I I I I I I I I I I I I I I I	In.
Director	018-26-0080   1 X M 2 F 71 Yrs.   Months Days Hours Min.	January20,1936	Massachus
any was we	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
<b>*</b> .*	Baltimore		1 X Yes 2 No
Maryland 28a-f show d at once.	Maryland Bartimore 10f. Zip Code	10g. Citizen of What Cour	ntry?
the Ma or 2	1100 Cathedral Street 21201	U.S.A.	
after death with the Maryland "al", or items 23a or 28a-f shu iner must be notified at once iner must Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp. 12. Was Decedent of Hispanic Origin? (Sp. 13. Was Decedent of Hispanic Origin?) (Sp. 14. Was Decedent of Hispanic Origin?) (Sp. 15. Was Decedent of Hispanic Origin?) (Sp. 15. Was Decedent of Hispanic Origin?) (Sp. 16. Was Decedent of H		ican Indian, Black,
er deat		Specify: Whi	te
	15 December 1 Structure (Specific plus highest grade completed) 16g December 1 Israel Occupation (Give kind of v	work done 16b. Kind of Business/l	
an "na cal Ex	Elementary/Secondary (0-12)  College (1-4 or 5+)  Real Estate Investo  17. Father's Name (First Middle Last)		ate
within jene.	4 Real Estate Investo	e (First, Middle, Maiden Surname)	
uld be filed within 72 hours Montal Hygiene. marked other than "nature event, the Medical Exam	7 - 1 3 1 -	n M. Mullen	
Me Me	19a Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Informant's Name/Relationship (Type, Print)	Rural Route Number, City or Town, State	, Zip Code) 0303
es I and 2 sho of Health and If item 27 is her tranmati	Deborah Rock/ Niece 16 A Deerwood Driv	Date   20c. Location - City or	Hampsnire
es I and of Healt If item	20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other place)		
permit. Page Department o Important: injury or oth	1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify:  St. Patrick Cemetery  3 News and Address of Excility Movements	zullo Funeral Chapel, P	Massachus
permit Depar Impor	21. Signature of Funeral Service Licensee  22. Name and Address of Facility Mary  6009 Harford Road Balt	• '	.A.
ysician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of	or respiratory arrest, shock, or heart	Approximate Interval Between Onset and
Medical	failure. List only one cause on each line.  Immediate Cause (Final disease a. Hypertensive cardiovascular disease		Death
caminer	or condition resulting in death)  Due to (or as a consequence of):		
	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):		
	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C. Due to (or as a consequence of):		<del> </del>
h certificate be executed tending physician and use as the burial - transit	X AMENDED 22, perFD, 23a, 27, perME, C869, 7/19/07 TT		
certificate b iding physics se as the bu	IF FEMALE: 23c. If yes, outcome of pregnancy	23d. Date of deliver	Day Year
e death certificat the attending phy ed for use as the	b l sol. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnant at time of death 5 Other (Specify)	Month	buy roar
the att	1 Yes 2 No 9 Unknown g Unknown	23e. Did tobacco use contribute to	the privace of death?
ires that the d signed by the l be detached	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	1 Yes 2 No 3 Pro	
quires en sigr uld be			utopsy findings available
law requi	E CO	performed? death?	
ng Physician: The law requir After this certificate has been s ineral director, page 2 should l		Yes 2 No 1 Y	es 2 No
ling Physician: After this certifi	examiner?   Hospital: 4   Innation: 2   FR/Outnation: 3   DOA   Other: Nursi	ing Home 5 Residence 6 Other	er: Scene
ng Phy	27 Manner of Death 28a, Date of Injury 28b, Time of Injury 28c, Injury at Work?	28d. Describe how injury occurred	
tal or Attendir rs after death. al Director: A led in by the fu	1 X Natural 5 Pending 2 Accident Investigation		
or Att	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (Street and Number or R or Town, State)	ural Route Number, City
ospital or hours afte meral Dir y filled in		and due to the cause(s) and manner as sta	ated
To the Hospital or Attending Physician: The law requires that the death within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for the completely filled in by the funeral director, page 2 should be detached for the completely filled in by the funeral director, page 2 should be detached for the completely filled in by the funeral director.	medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred	at the time, date and place, and due to t	he cause(s)
To wit To con	and manner stated.  29b. Signature and title of certifier  29c. License number	29d. Date signed (Mi	
	Carde Hallan O.C.M.E.	June 28, 2007	
'	30. Name and address of person who completed cause of death (Item 23a)	04	
	Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 212	01	
Sta Registr	THE TENTON AND THE PLANTAGE P		
H 17 Rev 1/200			
11 110 V 1/200	OI ORIGINAL		

Division or Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 72 hours after death with the permitar of Health and Mental Hyglene.  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 72 hours after death with the permitar of Health and Mental Hyglene.  Important: If item 27 is marked other than "natural"; or items 23a or 21 and 2 should be felached for use as the burial-transit or the Function of the Funct	11. M 1 3 Electric 17. F 19a. 20a. 21. § 23a.	23a. Imm disea resu	Sequil caus Caus Caus that resu	IF FI 23b.		25. \ 6	29a	30.1	31.
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	To Be Completed by Funeral Direction		dical Examiner	y Physician/Me	Completed b		Medical Ce		rar
Division or Vital Records, P.O. Box 68760,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28, any injury or other traumatic event, the Medical Examiner must be not once.	Physician	Examiner	s that the death certifined by the attending le detached for use as	n: The law requires ficate has been sig nr, page 2 should be	or Attending Physicial fler death. Director: After this certii in by the funeral directo	Fo the Hospital within 24 hours a Fo the Funeral I completely filled	3	Regist
	Baltimore, Maryland 21215-0036	e sa equi	8760,	s, P.O. Box 6	al Records	ivision or Vit			

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-	for State Registrar			, , , , , , , , , , , , , , , , , , , ,		tificate of L			Reg. No.	007	21660	
	Registrar     Decedent's Nam	e (First, Middle,	Last)					2. Date of De	ath		3. Time of Death	
Physician /Medical	Suzar	ine :	Kasmus					June	Day 17	2007	05 10 AM	
Examiner	Battimo	re Wa	Slington Me	dival Co		4b. City, Town, or	Buch		ANN		rundel	
uneral Pirector	5. Social Security N 220-88-03	84	6. Sex 7. A 1 M 2 XF	Age (In yrs. Ia 40	Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Bir Octonth, Pa	1966	Cou	place (State or Foreign ntry) nington, DC	
*	Usual Residence o 10a. State	10b. County		10c. City,	Town or Loc	ation					10d. Inside City Limits	
fied at	Marvland	Baltim	nore		Ph	oenix					1 ☐ Yes 🔏 No	
or 28a-f s se notified Directo	10e. Street and Nu					10f. Zip Code			10g. Citizen o	What Cou	ntry?	
st be	13407	Blvthe	enia Road			21:	131		Uni	ted S	tates	
Department of health and Mehnal hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	11. Marital Status 1 ☐ Never Mari	ried 2□ Marri	12. Was Deceder Armed Forces	s? <b>X</b> No		Vas Decedent of Hi Yes, specify Cuba □Yes 2XNo		pecify Yes or No Rican, etc.)	Spec	ace - Ameri ack, White, ify: W		
yglene "natural ner than "natural t, the Medical E	(Spe	15. Decedent cify only highes	's Education it grade completed)		16a. Deced (Give	ent's Usual Occup kind of work done o OO NOT use retired	ation during most of work	king	16b. Kind of	Business/Ir	ndustry	
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e Co	17. Father's Name	(First, Middle, I	Last)				18. Mother's Nam	ne (First, Middle	, Maiden Surna	ame)		
wental H arked ott atic even	Barry V	. Van I	Demark				Mar	y E. Ste	evens			
tn and M 7 is mar traumat	19a. Informant's N	lame/Relationsh		r	1	g Address (Street a					ip Code) 705	
tem 2	20a. Method of Dis		Ratk, Tache			sition (Name of natory or other place		Date	20c. Location		own, State	
innem of tant: If it	4 ☐ Donation	5 ☐ Other (Sp			Lincol	n Cemetery	June 2	21, 2007			Maryland	
Impor any In	21. Signature of F	red b	complications that cause only one cause on each	dt.	<sup>2</sup> [	Name and Address Onald V 4400 Powd	s Borgwar er Mill	dt Fune: Road, B	ral Hom eltsvil	e, P. le, M	A. ID 20 <b>7</b> 05	
urial-transit usional usiona	Immediate Cause disease or conditive resulting in death)  Sequentially list of any, leading to a cause. Enter Und Cause (Disease of that initiated even resulting in death)	onditions, minediate erlying ringury is	b. Due to (or o	ro Fut as a consequence of the fire as a consequence as a consequence	ence of):	1 Bleedi	» ;		-		Onset and Death	
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	IF FEMALE: 23b. Was decede in the past 1: 1 ☐ Yes 2 9 ☐ Unknow	2 months?		n 2 □ Fetal t at time of de	death 3	Ectopic pregnancy Other (specify)				Date of deli Month	very Day Year	
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within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use Medical Certification: To Be Completed by Physician/M	24a. Was an autopsy performed?  1 Yes 2 No 3 Probably 4 Orikinown  24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No 1 Yes 2 No											
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thin 24 hours of the Funeral ompletely filled	29a. Certifier (Check only one)		ng Physician: To the be Examiner: On the bask and manner	s of examinat								
o the smple	29b. Signature an	d title of certifie		Stated.		29c. Licens	e number		29d. Date sig	ned (Month	n, Day, Year)	
≱ ⊢ δ	b L	Cam 7	Las My			29c. License number 29d. Date signed (Month, Day, Year)  Tune 17, 2007						
	, ,	<u> </u>	1.100							,		
3	30. Name and add		who completed cause o			Print\	Henry	FRAN		ιÞ.		

Registrar

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** 16, 2007 10:30 PM June Pauline E. Scott /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Montgomery Washington Adventist Hospital Takoma Park If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
May 2, 191 Birthplace (State or Foreign Country) . Age (In yrs, last birthday, **Funeral** Days Months 1 □ M 2 😾 F Director 579-12-4680 96 1911 Clifton, VA Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 shov any injury or other traumatic event, the Medical Examiner must be notified at 1 ☑ Yes 2 ☐ No Director DC N/A Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code filed within 72 hours after death with thygiene.

Thygiene.

Ther than "natural", or items 23a or 5 1318 Webster St., N.E. 20017 U.S. by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 □ Never Married 2 □ Married Afro-American Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No If Yes, Give Year or Dates: Specify 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Fed. Gov't. Statistician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walter Hopkins Alice Eubanks Hopkins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 410 McLane Ct. Rockville, MD 20850 Denise Isrene / Granddaughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) June 21, 2007 Landover, MD 0 Harmony Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McGuire Funeral Service, Inc. 7400 Georgia Ave., N.W. Washington, D.C. 20012 23a. Part1. Enter the disease, or complications that daysed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) condin **Physician** /Medical ence of): Due to (or as a conseq Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner been signed by the attending physician and should be detached for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed 1☐ Yes 2 NO To the Hospital or Attending Physician: funeral director, 25. Was case referred to/medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 1 Impatient 2 □ ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide within 24 hours a 29a. Certifier 1 🚅 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) EHTA MD ロところ 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 20 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 200<sup>Year</sup> **Physician** 16, 5:13 June Barbara Schwartz Seidel а м /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel 468 Riverview Drive Edgewater If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months 6/5/1942 Year) 1 □ M 2 🛛 F Hours Washington, DC 579-54-3246 65 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show notified at MD Anne Arundel Edgewater 1 ☐ Yes XX No Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Examiner must be 468 Riverview Drive USA 21037 items 23a Pages 1 and 2 should be filed within 72 hours after death 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ∐Yes 2**∑X**lo If Yes, Give Year or Dates: 1 Never Married 2 Married o. Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 ☑ No þ Specify: 3 Widowed 4 Divorced "natural", Completed permit. Pages 1 and 2 should be filed within 72 h. Department of Health and Mental Hyglene. Important: If item 27 Is marked other than "natul any Injury or other traumatic event, the Medical once. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Dental Hygienist Denta1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Isadore Schwartz Mary Ziets 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mindi Seidel-Adler Daughter 86 West Square Drive Richmond, VA 23238 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State XXBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/18/2007 Mt. Lebanon Adelphi, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Hardesty Funeral Home, P.A. Gall 12 Ridgely Ave. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Months Varian /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the Hospital or Attending Physician; The law requires that the death certificate be executed physician and s the buriat-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ 2 Fetal death in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4□Pregnant at time of death ed by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has 9.2 s autopsy certificate ha 2□ No 1□ Yes 2**√20**No 1 TYes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes VINO 1 🗀 Inpatient 2 ER/Outpatient 3 DOA Certification: To this ā Date of Injury (Month, Day Year) 27. Manner of Dath 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 2 Accident 5 Pending investigation Injury within 24 hours arter account to the Funeral Director: Af 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Tackrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifie Medical nd manner stated 29b. Signature and title of cer 29c. License number 29d. Date signed (Month, Day, Year) DS8166 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Marcalus 3/69 Broverton St, Suite 101 Resember, MA) 21037 C. 31. Date filed (Month, Day, Year) State JUN 1 9 2007 Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ( Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death June 29, 2007 **Physician** Year 4:45 A ANNA HARRIMAN TACCINO /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner WMHS-Frostburg Nursing & Rehab Ctr **Allegany** Frostburg If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 12-11-1914 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days 1 ☐ M 2 🖫 F 92 MARYLAND 214-07-3923 Director Usual Residence of Decedent 10c. City, Town or Location r 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits Director TY Yes 2 No ALLEGANY FROSTBURG MD 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? "natural", or items 23a or : 21532 UNITED STATES 160 W. MAIN STREET permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or items 23s any injury or other traumatic event, the Medical Examiner must any injury or other traumatic event, the Medical Examiner must once. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Specify: WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) LAB TECHNICIAN CELANESE CORP. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MARY BANNATYNE HARRIMAN WILLIAM HARRIMAN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 156 W. MAIN STREET, FROSTBURG, MD 21532 NIECE ANN WARNE 6-30-2007 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XICremation 3 ☐ Removal from State CUMBERLAND CREMATORY CUMBERLAND, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Han M Soc 22. Name and Address of Facility 60 W. MAIN STREET SOWERS FUNERAL HOME, P.A. Sowers FROSTBURG, MD 21532 MO0547 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Intra ctable CONGESTIVE Physician Low years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of, Examine Hospital or Attending Physician: The law requires that the death certificate be executed 14 hours after death. physician and the bunal-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Be Completed by BRONARY ARTER 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an certificate ha autopsy performed 2 17 No 1∐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ို 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manuer of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Medical Certification: (Month, Day Year) 1 Natural 5 Pending Injury s after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours af To the Funeral D completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the

State Registrar



**ORIGINAL** 

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

Brosdovay Frostburg Maryland 2(532

SATURNING 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

CHANG M.Q 32. Registrar's Signature

Division or Vital Records, P.O. Box 68760

DHMH 17 Rev 1/2001

State

Registrar

29b. Signature and title of certifie

29c. License number

29d. Date signed (Month, Day, Year)

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 6/29/2007 **Physician** James H. Welch 4:25 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Vindobon<u>a Nursing Home</u> Frederick nder 1 Year | If Under 24 Hrs. Frederick Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Months Days 1XM 2□ F Min. Director 90 GA 712-09-7102 2/4/1917 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 X No Director MD Frederick Frederick 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 8619 Burnt Hickory Circle USA Funeral 21704 Armed Forces? X☐ Yes 2☐ No if Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4 □ Divorced WWII White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clerk <u>Union Pacific RR</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Be ပ Luther Herman Welch Lula Henrietta Parker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael J. Welch Son 8619 Burnt Hickory Circle Frederick MD 21704 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 □Removal from State 4 Donation 5 Dother (Specify) 7/6/2007 Pocatello, Idaho Restlawn Mem. Grds. 22. Name and Address of Facility Keeney & Basford P.A. F.H. 106 East Church Street Frederick MD 21701 M01176 23a. Partt. E. er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, if heart failure. List only one cause on each line. Immediate Cause (Final disease for condition as a consequence of the condition of condition of condition of condition of condition of conditions are consequence of the condition of condition of conditions are consequence of the conditions are consequence of the condition of conditions are consequence of the conditions are conditions are conditions are consequence of the conditions are conditions are conditions are conditions are conditions. Approximate Interval Between Onset and Death Due to (or as a consequence of): **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or mile,) that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ 0 Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division or Vital Records, P.O. Box 68760,4 $\mathcal C_{\mathcal C}$ 

Certification: To

27. Manner of Death Natural 5 Pending investigation 2 Accident 3 Suicide

4 Homicide

(Check only one)

29a. Certifier

6 Could not be determined

1 🗀 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Iniury

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28d. Describe how injury occurred

Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number mp056890 29d. Date signed (Month, Day, Year)

30-Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) Registrar's Signature

Registrar

Medical

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Physician /Medical Examiner

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signed by the atte

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certificate has page 2

After

within 24 hours after death

To the Funeral Director:

physician

The law requires that the death certificate be executed

P.O. Box 68760.

Division or Vital Records,

or Attending Physician:

To the Hospital

Physician

/Medical

**Examiner** 

10a. State

Director

Funeral

Completed by

Be

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Examiner

Physician/Medical

Completed by

Be

Certification: To

Medical

VA.

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If term 72 is a marked other than "natural", or Items 23a or 28a-f show important: If them 77 is marked other than "natural", or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.

UCORDHARY ARTERY DISBASE, @ LEFT LEG WOUND INFECTION 3) PREVIOUS RESPIRATORY FAILURE

DYBPATIC BY CEPHALD PATH

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No -24a. Was an

SNEHAL THSUFFICIENCY, @ SEVERE AHEMIA, @ HYPOALBUMINEMIA 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital:

1 ☐ Yes 2 No 27. Manner of Death 1 Natural 2 Accident

5 ☐ Pending investigation 6 ☐ Could not be determined

1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury 28h Time of (Month, Day Year)

28c. Injury at Work?

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only

3 ☐ Suicide

4 Homicide

🗺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier Morammed A. Marman MD 29c. License number

29d. Date signed (Month, Day, Year) SUNE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MOHAMMEDA, MARNAR MD, 33 31-TERNACE, HYATTS OLEDO

State Registrar 31. Date filed (Month, Day, Year) JUN 2 0 2007



DHMH 17 Rev 1/2001

			For State Registrar	State of Mar		Certificate		ath		Reg. No	0000	7 2	1668
	Physici	an	Decedent's Name (First, Middle, La     William Edward						2. Date of De Month June 1	Dat	2007 Yea	,	ime of Death  :05 P M
	/Medio		4a. Facility Name (If not institution, give			4h City To	wn. or Loca	ition of Death	Julie 1		County of De		
	Examir	ier	Laurel Regional				aurel				ince G		e's
	Funeral		5. Social Security Number 6. 5	Sex 7. Age (	In yrs. last birth	day) If Under 1	rear If U	nder 24 Hrs.	8. Date of Bir	rth	9. E	_	State or Foreign
She is	Director		213-12-1/91	1XJM 2□F 8	4 Y	s.	ays 110	dio iviiri.	Feb. 1	8, 1	1923 M	lary1a	ind
	and ww		Usual Residence of Decedent  10a. State 10b. County	1	0c. City, Town	or Location						10d. Ins	side City Limits
	Marylisho f sho	គ្ន	Maryland Prince (	George's		Beltsvi	116					}	∐Yes 2XMo
	r 28a	Directo	10e. Street and Number	deorge 5		10f. Zip Co				10g. Cit	izen of What	Country?	
	th with		4322 Franklin T	Terrace			20705			Ur	nited S	tates	
	r dea lems er m	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S.	13. Was Deceden If Yes, specify	t of Hispan Cuban, Me	ic Origin? (Spec exican, Puerto R	ify Yes or No	o-	14. Race - Ar Black, Wi		ian,
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy lury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ሺ No If Yes, Give Year or Dates:		1 □ Yes 2 <b>X</b>						White	•
2-0	"natu	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. E	ecedent's Usual C Give kind of work of ife. DO NOT use i	ccupation done during	most of working	g	16b. K	ind of Busines	ss/Industry	
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ary	should and Men s marke umatic	-	19a. Informant's Name/Relationship			Mailing Address (S						, Zip Code	20904
	and 2 ealth a n 27 is her trau		Pamela J. Stover		131	.50 Old C	olumb						
ore	of He		20a. Method of Disposition  1X Burial 2 Cremation 3	Removal from State	20b. Place of I cemetery	Disposition (Name crematory or other	of er place)	Da	ite	20c. Lo	ocation - City	or Town, St	ate
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Baltimore,	permit. Departr Importa any Inju		21. Signature of Funeral Service Lice	nsee	4	Donald 4400 Po	Address of I	orgward	t Fune	ral	Home,	PA	V.
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			shock, or heart failure. List only	one cause on each line.			ii uyirig, su	on as cardiac or	respiratory a	arrest,		Inten	oximate val Between et and Death IUTES
	Physician /Medical		disease or condition resulting in death)	Cerebral  Due to (or as a control of the control of			_					min	utes
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			IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf	pregnancy						23d. Date of o	felivory	
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ec C	has be ye 2 sh	ple							24a. Was		24b. Were	autopsy fin	dings available on of cause of
<u></u>	: The	Completed							perfe 1∐ Yes	ormed? 201 No	death		
Vital	sician: The la certificate ha irector, page 2	Be	25. Was case referred to medical examiner?	Hospital:				Place of Death	(Check only	one)			
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Division or	ding h. h. After funer	ig	1 Natural 5 ☐ Pending	(Month, Day Y		ury M	Injury at Work? 1 ☐ Yes	1	od. Describe	now inju	ry occurred		
ISI	Atten deatl	fical	3 ☐ Suicide 6 ☐ Could not b	28e. Place of injury	- At home, fam				3f. Location (	Street ar	nd Number or	Rural Rout	e Number,
á	al or after	Certification:	4 ☐ Homicide determined	building, etc. (	Specify)				City or To	wn, State	e)		
	To the Hospital or Attenc within 24 hours after death To the Funeral Director: completely filled in by the	Medical (	29a. Certifier 12 Certifying P (Check only one) 2  Medical Exa	hysician: To the best of r miner: On the basis of ex and manner state	kamination and	death occurred at or investigation, in	the time, da	ate and place, a n, death occurre	nd due to the d at the time	cause(s , date an	) and manner d place, and d	as stated. lue to the c	ause(s)
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier	1 /11		29c L	icense num	ber			te signed (Mo	4	
			> Willen !	T Ware	n. W.	0 !	)13	916		Ju	ne /6	0,20	90 Z
	/2		30. Name and address of person who				C+	T 01 1	MD 0	0070-	7		
		to	William A. Warre	en, MD 321		George	DL.,	Laure1,	מוא 2	20707	•		
	Sta Registi		JUN 2 0	309	-	Coarte							
DHI	MH 17 Rev 1/2			J. C. C. C. C.	200	The same of the sa							

DHMH 17 Rev 1/2001

			State	of Maryland	d / Depa		lealth ai	nd Mental Hy	giene	0 n 7	21669		
			Registrar  1. Decedent's Name (First, Middle, Last)		Cei	lilicate of	Dealii	2. Date of D	Reg. No.		3. Time of Death		
	Physicia		Louis R. Wingo, Sr.					June	14	2007	5:30 p M		
	/Medic Examin		4a. Facility Name (If not institution, give street and							nty of Death			
	LAGITIII		Corsica Hills Genesis	Healthcar	re	Cent	reville	e	Que	een An	nes		
	Funeral		Social Security Number     6. Sex	7. Age (In yrs. la		If Under 1 Year Months Days	If Under 24	4 Hrs. 8. Date of Bi (Month, D	rth av. Year)	9. Birthp	place (State or Foreign		
9	Director		220-22-5327 <sup>1⊠M 2□</sup>	<sup>F</sup> 79	Yrs.	Wioritis Days	110013	Feb. 2	7, 1928	8	MD		
	put 🔏		Usual Residence of Decedent  10a. State 10b. County	10c City	Town or Lo	cation					0d. Inside City Limits		
	anyla eho	៦	MD Anne Arundel				rnold				1 ☐ Yes 2 🎛 No		
	28a-1	ect	10e. Street and Number			10f. Zip Code			10g. Citizen o	of What Cour	ntry?		
	with Sa or	<u>=</u>	316 Stevens Avenue				012		•	USA	•		
	within 72 hours after death with the Maryland ene. then "natural", or Itama 23e or 28e-f ehow the Madical Exeminar must be mulified at	Funeral Director		Decedent Ever in U.S	i. 13. \	Was Decedent of H	lispanic Origi	in? (Specify Yes or N Puerto Rican, etc.)	o- 14. F	lace - Americ			
9	or ita	T.	1 Never Married 2 Married 1 SY	d Forces? es 2 ☐ No , Give WW]		ryes, specny Cuba 1 ∐ Yes 2 🙀 No	Specify:	Pueno Rican, etc.)		llack, White, cify: Whi			
03	rai', c	d by	3 Widowed 4 Divorced Year	, Give WW_ or Dates:	L-L	TEL TOS ZEZINO	Specify.						
2	72 h	Completed	15. Decedent's Education (Specify only highest grade complet	ed)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of	of working		Business/In	dustry .lding &		
12	within ane. then	E G	Elementary/Secondary (0-12) Colleg	ge (1-4or 5+)	1116. 1	Machini	,		Dry D	-			
d 2	Hygie ther ont, II		17. Father's Name (First, Middle, Last)			1100:11111	,	's Name (First, Middle			<u>F</u> ca - 7		
a	id be ental ked o	To Be	Dr. Charles Wingo				Emma	Marie Kel	ly				
Maryland 21215-0036	shoul nd M mar	-	19a. Informant's Name/Relationship (Type, Print)		19b. Mailir	ng Address (Street	and Number	or Rural Route Numb	per, City or Tov	vn, State, Zip	Code)		
Σ	alth a 27 is		Rose Mary Wingo/Wife		316	Stevens	Avenue	e, Arnold,	MD 21	012			
e,	of Her		20a. Method of Disposition	20b. Pla	ace of Dispo	sition (Name of natory or other place	се)	Date	20c. Locatio	n - City or To	own, State		
Ĕ	Page nent o int: if iry or		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal fr 4 ☐ Donation 5 ☐ Other (Specify)	UIII SIAIH	Veter	ans Ceme	tery	June 18,	2	sville			
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural; or itama 23a or 28a-1 show any njury or other traumatic event, II a Macinal Exeminar must be multified at once.		21. Signature of Funeral Service Licensee	The state of the s	B:	Name and Address & STRANCO	ss of Facility Sons	, P.A. Sev e Hwy, Sev	erna Pa	rk Fu	neral Home		
8,			23a. Part1. Enter the disease, or complications the shock, or heart failure. List only onercause	nat caused the death.							Approximate Interval Between		
	Physician		///	milde	120	why					On et and Death		
	/Medical		resulting in death)	to (or as a conseque	ence of):				····		19		
	Examiner		Sequentially list conditions b								*		
	p ii	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	s to (or as a consequ	ance of):								
	and and I-tran	хаш	that initiated events c. resulting in death) Last Due to (or as a consequence of):										
760,	icate be executed physician and the burial-transit	calE											
687	icate phys s the		d.										
X (	that the death certifica ed by the attending ph detached for use as th	Physician/Med		, outcome of pregnan					23d.	Date of deliv	ery		
Вох	death a atter	clar	in the past 12 months?	ive birth 2 ☐ Fetat or regnant at time of de		Ectopic pregnanc Other (specify)	у			Month	Day Year		
o.	t the c by the acheo	hys	9 ☐ Unknown 9 ☐ U	Inknown									
۳,	law requires that the as been signed by the 2 should be detache	by P	Part II. Other significant conditions contributing	to death but not resul	iting in the u	nderlying cause giv	ven in Part I.	23e. Did	tobacco use c	ontribute to t	he cause of death?		
Vital Records,	w require been sig should b							1	Yes 2 M	3 ☐ Prol	bably 4 ∐Unknown		
BCC	has be	Completed						24a. Wa	s an 24	b. Were auto	opsy findings available ompletion of cause of		
Ē.	The ate h page	NO.							formed? 2 No	death? 1 ☐ Yes			
/ita	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?			100		of Death   Check only	one				
<b>d</b>	Physician: this certific ral director.	2			R/Outpatier	I 3LI DOA		sing Home 5 Res			fy)		
nc On (		lon	1 Natural 5 Pending	Month, Day Year)	28b. Time o Injury	Wo	ryat rk? ]Yes 2∐N		how injury oc	currea			
isic	ten leatl tor: the	cat	2 Accident investigation 3 Suicide 6 Could not be	Place of Injury - At hor	me farm str		1103 2		(Street and Nu	mber or Rur	al Route Number.		
Division	lor A after Dire	Certification;		uilding, etc. (Specify)		con radiory, ornoc			own, State)				
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by		29a. Certifier	o the best of my know	viedge, deat	h occurred at the tr	me, date and	place, and due to the	e cause(s) and	manner as :	stated.		
	ne Ho n 24 t ne Fui	edical	(Check only 2 Medical Examiner: On the	he basis of examinati manner stated.	ion and/or in	vestigation, in my o	opinion, deatl	h occurred at the time	, date and place	ce, and due t	to the cause(s)		
	To the within 2 To the complet	Me	29b. Signature and title of certified	$\wedge$		29c. Licens	se number	27	29d. Date sig	ned (Month,	Day, Year)		
	110	4	Jan Y Dun	WW >		1	ノイトロ	50	6/1	21901	3 /		
	Did	T	30. Name and address of person who completed	cause of death (Item	23а) (Туре,	Plint)	1	36 w Chih	AA A	311	, C		
-	1-12		Go I frank	2108	P.	Darks	1)/0	w with	1/(1)	2/6	17		
	Sta Registi		31. Date filed (Month, Day, Yeal)  JUN 2 0 2007	32 Registrar's Signat	ure								
\$3	negisti	ar	3011 2 0 2001	were to	·	and a							

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# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Ma	ryianu / i	•	tificate of L			-	Reg. No.	2007	21670
	Physicia	ın	Decedent's Name (First, Middle, L     Aubrey Lee	Webster						2. Date of De Month	Day	Year	3. Time of Death
1	/Medic Examin		4a. Facility Name (If not institution, gi		0	Т	4b. City Town, or	Location	of Death	66	/4 4c.	O7 County of Dea	
	- Admini	<u> </u>	PENINSULA REGION					BUK				Vicem	
	Funeral Director			1011 005	(In yrs. last bi 76	rthday) Yrs.	If Under 1 Year Months Days	Hours Hours	Min.	8. Date of Bir (Month, Da	ay, Year)		thplace (State or Foreign ountry)
			Usual Residence of Decedent							2/26/	1931	Mā	ryland
	show	٦	10a. State 10b. County		10c. City, Tow								10d. Inside City Limits 1 □ Yes 2 ☑ Ye
	the M 28a-f notifie	Directo	Maryland Wicon  10e. Street and Number	1100	Sali	spur	10f. Zip Code				10g. Citiz	zen of What C	
	th with 23a or 1st be	a Di	32087 Shavox Ro	l			21804				USA	A	
036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. It of Health and Mental Hygiene. Or Item 27 is marked other than "natural", or Item 27 is marked other than "natural" or other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 Never Married 2 X Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:			Vas Decedent of Hi Yes, specify Cuba □ Yes 2[X]No	spanic O n, Mexica Specify		cify Yes or No Rican, etc.)		14. Race - Am Black, Whi Specify: wh	te, etc.
Maryland 21215-0036	"natur	Completed	15. Decedent's I (Specify only highest g	Education rade completed)	16a	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)				16b. Kii	6b. Kind of Business/Industry		
212	d withir giene. r than the Ma	ошо	Elementary/Secondary (0-12)	College (1-4or 5-			try Grow				Poul	ltry	
nd	be filed tall Hygie d other svent, the	BeC	17. Father's Name (First, Middle, Las							(First, Middle		Surname)	
<u> </u>	should be and Mental s marked o umatic eve	2	John Wesley Wek		10	h Mailin	g Address (Street a			Lee O		r Town State	Zia Cada)
Ma Ma	and 2 sho lealth and m 27 Is m her traum		Carolyn O. Webst			3208	37 Shavox	Rd.					2.ip Code)
Baltimore,	permit. Pages 1 and Department of Heall Important: If item 2 any injury or other once.		20a. Method of Disposition 1   Burial 2 □ Cremation 3		1		sition (Name of natory or other plac	e)		ate		cation - City o	
Ħ	nit. Pa artmer ortant: injury		4 □ Donation 5 □ Other (Special Signature of Funeral Service Lice		Parso		Cemetery Name and Addres	s of Faci	6/19			lisbury	, MD Association
e B	Dep Imp any	+ 4	David H. Bo	mpson (	FSP	5	01 Snow	Hill	Rd.,	Salis	bury,	, MD 21	804
П			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused y one cause on each lin	the death. Do	not ente	er the mode of dyin	g, such a	s cardiac c	r respiratory a	arrest,		Approximate Interval Between Onset and Death
	Physicían /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a	consequence	Tel	nu	رك	ger	us			
	Examiner		Sequentially list conditions	b									
	red sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence	of):							
ó	ificate be executed g physician and as the burial-transit	Ехап	that initiated events resulting in death) Last	CDue to (or as a	consequence	of):			<del></del>				
68760	icate be physicia s the bu	edical	•	d									
_		/Me	IF FEMALE:	23c. If yes, outcome p	of pregnancy							23d. Date of de	elivery
P.O. Box	The law requires that the death cert ite has been signed by the attending age 2 should be detached for use items.	Physician/M	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	1 □Live birth 4 □ Pregnant at 9 □ Unknown			Ectopic pregnancy Other (specify)				Month Day		
rds, F	w requires that the de been signed by the should be detached	by	Part II. Other significant conditions	contributing to death bu	t not resulting	in the un	derlying cause give	en in Par	t.		tobacco u Yes 2[		to the cause of death?  Probably 4 dunknown
Vital Records,	The law re te has bee age 2 sho	Completed								24a. Was auto perf		prior to	utopsy findings available completion of cause of
/ita		BeC	25. Was case referred to medical examiner?				1		ce of Death	(Check only			
	Physic this c	မ	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 Inpatier	nt 2 ER/O	utpatient		4 L I		me 5 ☐ Res 28d. Describe		6 □Other (Sp	ecify)
on	Attending Physician: Ir death. ector: After this certifici by the funeral director, I	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigati	(Month, Day		Injury	Worl	k? Yes 2[		204. 200020		, , , , , , , , , , , , , , , , , , , ,	
Division or	al or Attence after death Director: d in by the	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		ry - At home, f . <i>(Specify)</i>	arm, stre	eet, factory, office			28f. Location City or To	(Street an own, State	nd Number or F	Rural Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Direc completely filled in by	Medical C		Physician: To the best of aminer: On the basis of and manner sta	examination a	ind/or inv	vestigation, in my o	pinion, d	eath occuri	red at the time	e, date and	d place, and du	ie to the cause(s)
	To the within To the Comp	Me	29b. Signature and title of certifier		-0	<b>9</b> 1	29c. Licenso	e numbei	2		29d. Dat	te signed (Mor	nth, Day, Year)
)	160		1/		~ ~ e		H00		1410		6/	15/0	7
	OM	h a	30. Name and address of person who	D O	eath (Item 23a)	Type, I	ST JA	lish	1111	md	2180	01	
F	Sta Registr		31. Date filed (Montb, Day, Year)	2007 32. egistra	r's Signature	A	29c. Licenson  HOD  Print)  ST SA		71	, , , , ,			

		•	Stat  - State Amend #1 Per M Registrar	e of Maryland <b>E G8697/06/</b>	/ Depa <b>′07⊘J</b> F	rtment of He lificate of D	ealth and M Death		Reg. No.	) /	216/1
Di.				hristopher	2.57	Avant		2. Date of Dea Month	ath Day	Year	3. Time of Death
	/sicia ledic:	al	Christopher	1101	7 /			JUN	11 2 4c. County	007	202 CM
Exa	amine	er	4a. Facility Name (If not institution, give street ar Func Pricindel	400	50	4b. City, Town, or	pool in	5	4c. County	77	-
Fund			5. Social Security Number 6. Sex 1 M 2 D	7. Age (In yrs. lasi	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birti (Month, Day 1/31/19	h y, Year)	9. Birthpla Counti	ace (State or Foreign ry) NE
		-	Usual Residence of Decedent								
Marylan -f show	in Da	ţō	NE Douglas		Town or Loc aha	cation				10	d. Inside City Limits
h the	Total I	Director	10e. Street and Number	) Oinc	a III.	10f. Zip Code			10g. Citizen of W	/hat Countr	ry?
ath wit	71517		2589 Pratt Street			68111			USA		- India-
72 hours after death with the Maryland natural; or Items 23a or 28a-1 show	xaminer	by Funeral	1 Never Married 2 Married 1 If Ye	Decedent Ever in U.S. ed Forces? Yes 2 ☐ No is, Give r or Dates:		Vas Decedent of His Yes, specify Cubar ☐ Yes 2☑ No	spanic Origin? (Spanic Origin?), Mexican, Puerto  Specify:	ecity Yes or No- Rican, etc.)	Specify	e - America k, White, e : Bl. a	
72 hours	15	eted	15. Decedent's Education (Specify only highest grade compl	eted)	(Give I	ent's Usual Occupa kind of work done di	uring most of worki	ing	16b. Kind of Bu	siness/Indi	ustry
	event, the Medical	Completed	Elementary/Secondary (0-12) Coll	ege (1-4or 5+)		00 NOT use retired) s Rep			Brew	70 <b>7</b> 17	
should be filed within nd Mental Hygiene.	ent, II		12 17. Father's Name (First, Middle, Last)		bare		18. Mother's Name	e (First, Middle,			
Jid be Mental	tic ev	To Be	Harvey Avant				Martha 1	Pankey	•		
2 should have and have	emme	-	19a. Informant's Name/Relationship (Type, Prin	t)		g Address (Street a					
1 and Health Hem 27	thert		Al Avant/Son  20a, Method of Disposition	20b. Plac		6th Ave,		Bluffs	, LOWA 20c. Location -	51501 City or Tov	
Pages nent of H	ry or o		1 Buriat 2 Cremation 3 Removal 4 Donation 5 Other (Specify)	from State		sition (Name of natory or other place wn Cemete		/07	Omaha, 1	•	
permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other then	any inju once.		21. Signature of Funeral Service Ligensee	luce	22.	Name and Address 20 North	s of Facility	Chomas I	Funeral	Home	.10
			23a. Part1. Enter the disease, or complications shock, or heart failure. List only one cause	that caused the death.	Do not ente	er the mode of dying	, such as cardiac	or respiratory ar	rest,		Approximate Interval Between
Physic /Med			Immediate Cause (Final disease or condition resulting in death)	cu te C	And	iac,	Arrh	ythr	niA		Onset and Death
Exami			14	rterio	sale	rotic	Hear	4	Disen	50	
A B.	ınsit	mlner	cause. Enter Underlying Cause (Disease or injury	ue to (or as a consequent	108 OI):	100					
ficate be executed physician and	burial-tra	al Examin	that initiated events c	ue to (or as a consequer	nce of):						
		edical	d								
To the Hospitel or Attending Physicien: The law requires that the death certifuln 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending	ched for use a	Physician/M	in the past 12 months?	ss, outcome of pregnanc Live birth 2 ☐ Fetal de Pregnant at time of deal Unknown	eath 3	Ectopic pregnancy Other (specify)			23d. Dat Mo	e of deliver	ry Day Year
quires that n signed b	uld be deta	þ	Part II. Other significent conditions contribution  Dipbetes ;	g to death but not resulti	ing in the ur	nderlying cause give	on in Part I.		obacco use cont Yes 2 □ No		e cause of death?
The law reate has bee	page 2 sho	Completed						24a. Was autop perfo 1 Yes	osy rmed?	Were autoportion to combeath?	psy findings available inpletion of cause of 2 No
icien: Sertific	ector,	Be	25. Was case referred to medical examiner?	24		Othe	26. Place of Deat				
Physic of this of	ral dir	2	TOTES 2 NO	Date of Injury 2	Outpatien  8b. Time of	t 3 DOA 28c. Injury Work	4   Nursing Ho		dence 6 Oth		)
ading .: Afte	e fune	atlor	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		(? Yes 2 □ No				
or Atter	d in by the	Certification:	a Could not be	Place of Injury - At hom building, etc. (Specify)	e, farm, stre	eet, factory, office		28f. Location (S City or Tox	Street and Numb vn, State)	er or Rural	Route Number,
Hospite 24 hours Funeral	etely filler	edical C	29a. Certifier (Check only one) 1 Certifying Physician: 2 Medicel Exeminer: On an	To the best of my knowle the basis of examination manner stated.	edge, death n and/or inv	occurred at the time restigation, in my op	ne, date and place, pinion, death occur	and due to the red at the time,	cause(s) and ma date and place,	nner as sta and due to	ated. the cause(s)
To the within	compl	Me	29b. Signature and title of certifier	Dep	uty	29c. License	0605	4	29d. Date signer	1 (Month, [	Day, Year)
10			30. Name and address of person who complete	cause of death (Item 2	_	Print) 645	0605 An	ierie	A 2	103	35
Re	Sta gistr		31. Date filed (Month, Day, Year)	32 Registrar's Signatur	re Ann	all)	7				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 200 1:30 am Tok /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Summit Rusedale 2005 ave. 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth
(Month, Day, Year)
July 19,1925 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday, Funeral 1 XM 2 □ F Months 81 213-20-2083 Dundalk, MD. Director Usual Residence of Decedent 10c. City, Town or Location 10b County 10d. Inside City Limits show iral", or items 23a or 28a-f shov Exaπiner must be notified at 1 ☐ Yes 2 No Director Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7902 Wynbrook Road 21224 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black White etc. 1 □ Never Married 2 □ Married Maryland 21215-0036 'natural", or 1 ☐ Yes 2 💢 No Specify: Specify: White 3 Widowed 4 N Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 7 years Bethlehem Steel Crane Operator n and Mental Hygie 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ould be f Mary Dick Raymond Buckalew Department of Health and Men Important: If item 27 Is marker any Injury or other traumatic Pages 1 and 2 should 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 714 East McPhail Road, Belair, Maryland Mary Salisbury Daughter altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition July Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery Dundalk, MD. 2007 21. Signature of Funeral Service Licenses Conneily Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician YOCARDIAL /Medical Due lo (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 ☐Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 9☐Unknown Day 5 Other (specify) signed by the a 1 □ Yes 2 □ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 → 2 No 3 Probably 4 Unknown TABETES PERTENSFON 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 1 | Yes 2 | №6 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide tscertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32 Registrar's Signature

State

Registrar

31. Date filed (Month, Day,

Year

0 6 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death **Physician** Year 200 /Medical 4c County of Death 4b. City, Ton, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner TVENUE Under 24 Hrs. lours Min. 8. Date of Birth (Month, Day, Year) 6. Sex (In yrs. last birthday) **Funeral** Months Days Hours 1 M 2 1 -889 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 Pres 2 No Directo mor 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 206 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. þ 3 ☐ Widowed 4 ☐ Divorced BlAck "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ortant: if item 27 is marked other than "natu Injury or other traumatic event, the Mediral 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) MAIUST 17. Father's Name (First, Middle, Last) 18. Mother Name (First, Middle, Maiden Surname, Be ပ 19a. Informant's Name/Relationship (Type. City or Town, State, Zip Code) 19b. Mailing Address (Street and Number or Run Route Number md. 2120 Anisha 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If it 1 □ Surial 2 □ Cremation 3 ☐Removal from 4 Domation 5 □ Other (Specify) RISON 21. Sign of Funeral Service Li Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician counce 2 mutths /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records. P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) the 9 Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has le 2 autopsy performed this certificate har ral director, page 1∐ Yes 2 No or Attending Physician: To Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 20 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manne of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Natural (Month, Day Year) Injury 5 ☐ Pending investigation within 24 hours are: .....
To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3□ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 140 29c. License number 29d. Date signed (Month, Day, Year) 29h. Signature and title of certifier emilino DOS7436 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 s. Greene it. Bautinue mo 21201. 31. Date filed (Month, Day, Year) 3 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

JUL 0 6 2007

07-05055 Allen Burton Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

lien Burton		State of Maryland / Department of Health and Mental Hy - For State Certificate of Death	/gierie Reg.	No 200	7 2 1 6 7 1					
Physicia	<b>1</b> /	Registrar  1. Decedent's Name (First, Middle,Last)	2. Date of Death Month	Day Year	3. Time of Death 1245 hrs					
Medical Examin ಖಿ		Allen Burton  4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death	July 2, 2007	4c. County of Deat						
,		University Hospital  Baltimore								
Funeral Director		5. Social Security Number 219-86-7855 219-	8. Date of Birth	(MM/DD/YYYY) 9. Bi Forei , 1967 C						
2 1977 <b>* 2</b> 75 1 75 1 8 4 1 1 1 1	þ	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits					
iow any		10a. State MD 10b. County 10c. City, Town or Location Baltimore			1 XX Yes 2 No					
Maryland 28a-f show d at once	Director	10e. Street and Number	100	. Citizen of What Cou	intry?					
the M 3a or 2		4204 Main Avenue 21207		USA						
death with the Maryland or items 23a or 28a-f sho must be notified at once	Funeral	11. Mantal Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp. 12. Was Decedent of Hispanic Origin? (Sp. 13. Was Decedent of Hispanic Origin?) (Sp. 14. Was Decedent of Hispanic Origin?) (Sp. 15. Was Decedent of Hispanic Origin?) (Sp. 15. Was Decedent of Hispanic Origin?) (Sp. 16. Was Decedent of Hi	ecify Yes or No- Rican, etc.)	White, etc.						
fter dez [", or i		1 Yes 2 XX No specify:		Specify ican	American					
hours,'a	ed by	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of voluming most of working life. DO NOT use retired.)	red)	16b, Kind of Business	/Industry					
36 thin 72 lee. than "quedical E	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) unk	unk		unk					
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f she natic event, the Medical Examiner must be notified at once		17. Father's Name (First, Middle, Last)  18. Mother's Name	(First, Middle, Ma	aiden Surname)						
2121 uld be fil Mental F marked	o Be	Shadee Burton  19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or F		rah Burton er. City or Town, Stat	e. Zip Code)					
	۱	Hanifa Winder / Sister 4204 Main Avenue; Baltin								
ore, MC es 1 and 2 s of Health a If item 27	Ī	20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City of	r Town, State					
		4 Donation 5 Other Specify: King Memorial Park 07/0		Randallstow						
Balt permit. Depart Impor injury		21. Signature of Funeral Service Licensee  22. Name and Address of Facility  638 N. Gilmor Street		eral Home, P						
Physician	$\dashv$	23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiaco failure. List only one cause on each line.	r respiratory arres	st, shock, or heart	Approximate Interval Between Onset and					
/Medical :aminer		Immediate Cause (Final disease a. Multiple Gunshot Wounds	·.		Death					
1.		or condition resulting in death)  Due to (or as a consequence of):  Due to (or as a consequence of):								
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Box 68761 death certificate he attending phy defor use as the b	ian/	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnate pregnate at time of death 5 Other (Specify)	ancy	Month	Day Year					
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tal Rec	Be င	25. Was case referred to medical 26.Place of Death (Check	1							
Division of Vital Records, has or Attending Physician: The law requirers after death.  al Director: After this certificate has been sited in by the funeral director, page 2 should be	은	1 V Yes 2 No		Residence 6 Oth	er:					
ion of tending Pheath	ë	27. Manner of Death  28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?  1 Natural 5 Pending  28b. Time of Injury 1213 hrs  1 Yes 2 No	Subject shot							
ViSic or Atte fter des Directo	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (S or Town, St		Rural Route Number, City					
Divis lospital or At I hours after d uneral Direc		4 V Homicide determined (Specify) Local Street	2025 Guilford	Avénue, Baltimore						
Division of Vital Records, P.O. Box 68760, within 24 hours after death.  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Finneral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred.	at the time, date a	e(s) and manner as st and place, and due to	ated. the cause(s)					
To wit To con	Mec	and manner stated.  29b. Signature and title of certifier  29c. License number		29d. Date signed (A	fonth, Day, Year)					
		Alling Brassel MD O.C.M.E.		July 3, 2007						
2		30. Narie and address of person who completed cause of death (Item 23a)  Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD	21201							
St	ate	31. Date filed (Month, Day Year) 32 Registrar's Signature								
Regist		JUL 0 0 2001 Juliene 10. Juliene								

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036 The law requires that the death certificate be executed Hospital or Attending Physician: Medical Certification: To Director: / within 24 hours a To the Funeral L 1xCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. title of cep 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature at 52096 10+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) UTZSCHNEIDER. DAVID A. M. D. 7601 DRIVE. TOWSON. MARYLAND OSLER 31. Date filed (Month, Day, Year) Registrar's Signature

State Registrar

07-04988	

-rar	ncis Joseph		1- For State Certificate of Registrar			200 j. No.	7 2157
Mo	Physici dical Exami			,		Day Year	3. Time of Death 1430 hrs
Me	ulcai Exami	ner	CTURETS OCSEPTI REVEROUS	b. City, Town, or Location of De	June 30, 20	4c. County of Death	
			Worton Creek Marina	Chestertown		Kent	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24		(MM/DD/YYYY) 9. Bir	
	Director		159-48-2114 1XM 2 F 55 Yrs.	Months Days Hours I	Min. 02/12/	1953	untry) PA
			Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	on			10d. Inside City Limits
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7	larylar 18a-fs atom	Director	10e. Street and Number	10f. Zip Code	100	g. Citizen of What Cour	ntry?
2	the Nation 1	ä	7001 Brentwood Road	19151	,	United Stat	es
	ilmore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at once.	Funeral		Decedent of Hispanic Origin? es, specify Cuban, Mexican, Pu		14. Race - Ameri White, etc.	can Indian, Black,
	er dea		1 Yes 2 X No	Yes 2 X No specify:	, , , , , , ,	<sub>Specify:</sub> Whi	te
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	6 72 ho nn "na cal Ex	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	est of working life. DO NOT use	retired) .		
	within jene.	틹	4 Survey			Land Surve	eying
	15-		17. Father's Name (First, Middle, Last)  Joseph F. Bevenour, Sr.		ame (First, Middle, Manne) M. Moran	aiden Surname)	
	212 ould be Ment mark	To Be		Address (Street and Number		per, City or Town, State	, Zip Code)
	MD d 2 sho lth and n 27 is numat			Brentwood Road			
	of Hea		20a. Method of Disposition  1 Burial 2 X Cremation 3 Removal from State  R.A. Ferr	tion (Name of cemetery, er place)		20c. Location - City or	
	Limo Page ment or otl		4 Donation 5 Other Specify:			West Chest	
	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner muss be notified at once.	4	21. Signature of Funera/Service Licensee 22. N.	ame and Address of Facility D	avid J. We	eber Funera	l Homes, PA
	Physician	$\dashv$	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line.	1 S. Chester S e mode of dying, such as cardia	ac or respiratory arres	st, shock, or heart	YLANO ZIZSI Approximate Interval
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	Spital spital nours a neral	S G	4 Homicide determined (Specify) creek		Buck Neck		own, MD
	Division of Vital Records, P.O. Box 68760, within 24 hours after death.  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	ical	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurr (Check only one)  Wedical Examiner: On the basis of examination and/or investigation.				
_	To To Com	Medical	and manner stated.  29b. Signature and title of certifier	29c. License number		29d. Date signed (Mo	nth, Day, Year)
			Veryonie Mac Marco	O.C.M.E.		July 1, 2007	
	T		30. Name and address of person who completed cause of death (Item 23a)				
	0 '			enn Street, Baltimore, M	ID 21201		
	St Regis	ate trar	31. Date filed (Month, Day, Year)  32. Figure 132. Replicar's Signature	. e.			COME
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			For State Registrar	State of	Marylan	-	artment rtificate				ental Hy	gien	600	7	2167	17
4.		0	Decedent's Name (First, Middle, Lass)	t)							2. Date of De			V	3. Time of De	eath
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	/Medic Examin		4a. Facility Name (If not institution, give	street and nun	nber)		4b. City,	Town, or	Location of	of Death		4c. County of Death				
***			Wilson Health Ca	re Cent	er		Gai	ithei	rsbur	g			Mont	gomer	У	
5	Funeral		5. Social Security Number 6. Se		7. Age (In yrs.	last birthday)	If Under Months		If Under Hours		8. Date of Bir (Month, Da	th v Yea	(r)	9. Birthp Coun	lace (State or F	orei <b>g</b> n
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	pu »		Usual Residence of Decedent  10a. State 10b. County		10c Cit	ty, Town or Lo	cation							1	0d. Inside City L	Limite
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Maryland 21215-0036	C) (0 = 6		19a. Informant's Name/Relationship (7								Route Numb					- 4.4
	1 and 3 Health tem 27 other tr		M. Elizabeth Sans	bury (					Iill I						nia 220	<u> </u>
9			20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐	Removal from S	Ctota C	Place of Dispo cemetery, crer	natory or of	ther place			ate	20c.	Location -	City or To	wn, State	
<u>E</u>	ment ment tant:		4 □ Donation 5 □ Other (Specify	)	Gr	een Mo	unt Ci	remai	tory	//5/	0/				Maryland	<u>d</u>
Baltimore,	permit. Page Department of Important: If any injury of once.		21. Signature of Funeral Service Licen	s <i>e</i> e		22	Mitche Mitche	d Addres ⊇II-\	s of Facility	feld	Funer	al I	Home,	Inc.		
	0.0 ≥ € Ø		Slevye / to	enai	~		6500	Yor	k Roa	ad Ba	altimo:	re,	Mary	land	21212	
15 4		N.	23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that ca one cause on ea	aused the deat ach line.								1		Approximate Interval Between Onset and Dea	en
I	Physician		Immediate Cause (Final disease or condition	a fcu	itec	ereb	2021	asi	cell	are	icci	Le.	ut	(	me no	nlh
融	/Medical Examiner		resulting in death)	Due to (	or as a conseq	(uence of):										
			Sequentially list conditions.	b. Due to /	or as a consec	wanaa af\:								-		_
ء در	led Isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	20010 (	DI 23 & COI1364	juditud Otj.										
)_	xecul and al-trar	xan	that initiated events resulting in death) Last	c. Due to (	or as a conseq	uence of);					_			-		
8/60,	cate be executed bhysician and the burial-transit	alE														
9	ficate phy: s the	edical		d												
ROX	eeth certifi ettending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outo									23d. Dat	e of delive	ery	
ň	deeth ette	ciai	in the past 12 months?	4 Pregna	rth 2 ☐ Feta ant at time of d		Ectopic pre Other (spe						Moi	nth	Day Yea	ar
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ري ح	The law requires that the deeth certific te has been signed by the ettending bage 2 should be detached for use .s	by P	Part II. Other significant conditions of				nderlying ca	ause give	n in Part I		23e. Did	tobacco	use conti	ribute to th	e cause of dea	ith?
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		Ф	25. Was case referred to medical	J.			-		26. Place	e of Death	(Check only		10		20,10	
>	Physici this ce al direc	To B	examiner? 1 🗆 Yes 2 🖸 No	Hospital: 1 🗆 Ir	npatient 2	ER/Outpatier	t 3 DO	A Othe	91: 410 NL	ursing Hom	ne 5 Res	dence	6 □Oth	er ( <i>Specif</i> )	()	
0	ding Ph h. After th funeral		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date o	of Injury h, Day Year)	28b. Time o	f 2	Bc. Injury Work	at	2	8d. Describe	how in	jury occurr	ed		
Ö	ttendir death. ctor: Af y the fu	atic	2 Accident investigation		,,,	,,	М		Yes 2□	No						
DIVISION	or Attending Physician: after death. Director: After this certific in by the funeral director.	Certification:	3 Suicide 6 Could not be 4 Homicide determined	ZRA PIACA	of Injury - At h	ome, farm, str	eet, factory	, office		2	8f. Location (	Street wn, Sta	and Numb	er or Rura	l Route Numbe	ir,
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	To the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by	Medical	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exam	iner: On the ba	isis of examina	owledge, deat ation and/or in	h occurred a vestigation,	at the tim in my op	ie, date an pinion, dea	nd place, a ath occurre	nd due to the d at the time,	cause date a	(s) and ma ind place, a	nner as st and due to	ated. the cause(s)	
	To the Hos within 24 h To the Fur completely	Med	one) 29b. Signature and title of certifier	and mann	er stated.		200	Licenso	number			-204 E	Date signed	d (Month	Day Vasr	
	So So		250. Signature and title of certinel	7		0				110-						
	٠	1	municity and the second		eth	acla	10	00	10	1150	4//	10	ruy	0,0	2007	
	20		30. Name and address of person who	completed cause	e of death (Iter	n 23a) (Type,	Print) C	(a-1)	177	48R	ELL SKILL	G	MI	200	877	
182	Sta	te	31. Date filed (Month, Day, Year) 20		egistrar's Signa	ature	M.	- 1		, -/-		1	- 0			
	Registr		JUL U 5 ZU	de	Ester L	F. GO	3061									

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Bonaccorsi 2007 10:45 A.M Josephine Anna 3, July 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Baltimore Franklin Square Hospital If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Ohio 8. Date of Birth (Month Day Year) 5. Social Security Number 7. Age (In yrs. last birthday) Days 1 □ M 274-26-9723 77 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 👿 No Rosedale Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21237 USA 12 Brafferton Way 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2√2 No Specify Specifiwhite 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Giavanna Marisca Carmelo Gugliotta 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) David Venanzi/son-in-law 12 Brafferton Way Rosedale Maryland 21237 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 7/7/07 Parkwood Cemetery Baltimore Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 5305 Harford Road Leonard J. Ruck, Inc. Baltimore, Maryland 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) MIMUL Due to (or as a consequence of) ertensiv Sequentially list conditions, if any, leading to immediate cause. Enter Underlying ( as a consequence of):

Physician /Medical **Examiner** 

**Physician** 

Examiner

**Funeral** 

Director

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Health a

Department of Health Important; if Item 27 any Injury or other to once.

Director

Funeral

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Completed

Be

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760.

/Medical

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Cause (Disease of Injury that initiated events resulting in death) Last	c						
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑No 9 □ Unknown		3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year			
Part II. Other significant conditions  Ocheo with	contributing to death but not resulting in the $\mathcal{M} + \mathcal{I}'$	e underlying cause given in Part I.	23e. Did tobacco u 1 ☐ Yes 2	use contribute to the cause of death?  No 3 Probably 4 Unknow			
			24a. Was an autopsy performed?	24b. Were autopsy findings availabl prior to completion of cause of death?  1 □ Yes 2 □ No			
25. Was case referred to medical		26. Place of De	eath (Check only one)				
examiner? 1 ☐ Yes 2 💢 No	Hospital: 1 ☐ Inpatient 2 KER/Outpa	tient 3 DOA Other: 4 Nursing	Home 5 ☐ Residence	6 □Other (Specify)			
27. Manner of Death 1 Matural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Tim Inju		28d. Describe how injur	ry occurred			
3 ☐ Suicide 6 ☐ Could not I 4 ☐ Homicide determined		street, factory, office	28f. Location (Street ar City or Town, State	28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	nysician: To the best of my knowledge, d miner: On the basis of examination and/o and manner stated						

State Registrar 31. Date filed (Month, Day, Year)

Name and addres of person w

29b. Signature and title of certifie

person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature

9205

YORK Rd, St 102, TOWSON, MD, 21204

29c. License number

29d. Date signed (Month, Day, Year)

07-03-07

I Director:

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1- State Amend #20a-c, 22, perFH, g869, 7/9/07 Certificate of Death

Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** BENJAMIN MAURICE JUNE 1:50P 28 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Date of Birth (Month, Day, Year) 1**∑**M 2□F Months Days Hours Director 217-90-6914 54 Dec 21, 1952 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show ns 23a or 28a-f sho must be notified at MD Frederick Frederick 1 ☐Yes 2√ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 700 Toll House Avenue 21701 Funeral **USA** items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 No Specify Completed by Specify: black 3 ☐ Widowed 4 ☐ Divorced "natural" event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) unk disabled none 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk Be 27 is marked or traumatic ev Wilena Whittington ۵ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Sara Benjamin/sister 700 Pennsylvania Avenue #1 Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or o 1 MBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 KIOH 7/10/2007 state Deer Park Cemetery SMallwood, MD 21. Sime turn of Euneral Services Name and Add us of Facility ... In Jumbrun, & Mon., Co., 6028, Syke wille Rd. S Wad 21201 Eldersburg, MD 21784 MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or Indition **Physician** Cardiac resulting in death) /Medical Due to (or as a consequence of): Examiner rabable Sequentially list conditions, if any loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence of) The law requires that the death certificate be executed physician and s the burial-transit Exami Due to (or as a consequence of): Records, P.O. Box 68760. Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy signed by the atter in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 Probably 4 ☐Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No s certificate has b lirector, page 2 si 24a. Was an 1□ Yes 2 No Division or Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? director. 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 [] Inpatient 2 X ER/Outpatient 3 □ DOA Certification: To After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 2 Accident after death the 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical completely (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the I within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2007 D0060417 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Johnson 5 hah DY Hemen 1 homas

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUL 0 6 2007

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2007 **Physician** Day July 3:45p. M George Carr Jr. 1 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5407 Nelson Ave Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | O8 13 29 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 9. Birthplace (State or Foreign **Funeral** 1XM 2□F Director 218-22-2064 MD Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show a or 28a-f sh Director Tyr Yes 2 No MD Baltimore NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5407 Nelson Ave 21215 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mertal Hygiene. Important: If item 27 is marked other than "natural", or iter any finury or other thaumaite event, the Medical Examinet any finury or other thaumaite event, the Medical Examinet. Black, White, etc. 1 ☐ Never Married 2 🛱 Married 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Black Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Social Security Adm 12th grade Warehouse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Violia Simpson ٩ George A. Carr Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5407 Nelson Ave, Baltimore, Md <u>Doris Carr-Wife</u> 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet 7/9/07 Owings Mills, Md 22. Name and Address of Facility March F/H West 21. Signature of Funeral Service License ral. 4300 Wabash Ave, Baltimore, Md 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** PLENO (ARCINO MA OF THE PROSTATE TEN YEARS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and ohysician and the burial-transit Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year P.O. 5 Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. þ 2 No 3 Probably 4 Unknown 1 🔲 Yes Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No autopsy perform 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year) 32. I

ROBERTO

PILI

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Régistrar's Signature

D005196

JOHNS HOPKINS HOSPITAL N. 401 BROADWAY BALTIMORE MD 21231

**ORIGINAL** 

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last **Physician** ana July 2007 COM ( /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Aclems Shock Baltimore timore 1 reuma 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, 6. Sex 5. Social Security Number Days Year) **Funeral** 1 M 2 □ F 25, 214-20-7438 Director Usual Residence of Decedent 10d. Inside City Limits within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10h. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Abingdon Harford 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21009 20 Box Hill South Pkwy Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 11. Marital Status 1 ☐ Never Married 2 Married Specify: White 1 ☐ Yes 2 X No Specify: Baltimore, Maryland 21215-0036 þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Auto Salesman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be f nent of Health and Mental I int: If item 27 Is marked of Liboria Guzzo Sabastian Catalana 2 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20 Box Hill South Pkwy Abingdon, MD 21009 Catherine Catalana (Wife) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages Department of Important: If it 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State ò 07-06-2007 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) Bavview Crematory injury 22. Name and Address of Facility Schimunek Funeral Home of Bel Air 21. Signature of Fune at Service Licensee Inc. 610 W. MacPhail Rd Bel Air, MD 21014 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician raumatic /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transit APPROVED BY Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Completed by Physician/Medical OF RETIFICATION attending | IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) 4□Pregnant at time of death signed by the a 1 ☐ Yes 2 ☐ No 9∏Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 🗆 No 2 No 26. Place of Death (Check only one) 25. Was case referred to medical examiner?
1 ☑ Yes 2 ☐ No Be Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) မှ this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After Injury 1 ☐ Natural 2 ☑ Accident 5 ☐ Pending investigation ell, hit head on counter 4:00 P 2107 1 ☐ Yes 2 ☑ No death. neral Director; / 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 20 Boxhill South Apt 115 Alangdon, MD Athome e Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 29b. Signature and fille of certifier

Wood

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Greene

32. Paistrar's Signature

22

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DHMH 17 Rev 1/2001

within 2

29c. License number

29d. Date signed (Month, Day, Year)

			For State Ragistrar		State	of Marylan		artment <i>tificate</i>			ınd M	ental Hy	gien Reg. N	2001	21683
			1. Decedent's Name (Firs	t, Middle, La	st)							2. Date of D		Yana Yana	3. Time of Death
П	Physici /Medio		Margaret				Cox				J	$ \begin{array}{c} Month\\ \mathbf{u1y} \end{array} $	2	2007	12:00 P M
	Examin		4a. Facility Name (If not in	stitution, giv	e street and no	umber)		4b. City, T	Town, or	Location o	f Death		4	c. County of Deal	th
			803 Cashew					Bel A						Harford	
	Funeral		<ol> <li>Social Security Number</li> <li>202-12-4381</li> </ol>		ex □M 2√∏ F	7. Age (In yrs.		If Under 1 Months	1 Year Days	If Under 2 Hours	Min.	8. Date of B (Month, D	ay, Yea	r) 9. Birt	thplace (State or Foreign ountry)
	Director		Usual Residence of Dece		X	81	Yrs.					10-29-	192	5 Penn	sylvania
	land			County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
	Mary	ŏ	Maryland Ha	arford		Re	l Air								1 ☐ Yes 2√∑No
	288 1000	Directo	10e. Street and Number			БС	I AII	10f. Zip (	Code				10g. C	Citizen of What Co	ountry?
	3a or		803 Cashew	Ct					2	1014				S.A.	,
	me 2	Funeral	11. Marital Status		12. Was Dec	edent Ever in U	.S. 13. \	Was Decede			in? (Spe	cify Yes or N Rican, etc.)		14. Race - Ame	
9	or Its		1 Never Married 2	Married	Armed F	2 🗓 No		1 Yes, speci 1 □ Yes 2			, Puerto I	Rican, etc.)		Black, Whit	e, etc.
ဗ္ဗ	filed within 72 hours after death with the Maryland Hygiene. kther then "natural", or fleme 23e or 28e-f ehow sht, the Mudical Examinar must be notified at	d by	3 ☐ Widowed 4 💢 🖸	ivorced	If Yes, G Year or I	Dates:		10 105 2	IZY NO	эрөспу:				Specify: Wh:	ite
ς.	72 h Tratu	Completed	15. D (Specify on	ecedent's Ed y highest gra	ducation de completed	)	16a. Deced	dent's Usual kind of work DO NOT use	Occupa k done d	ation furing most	of workir	ng	16b.	Kind of Business	Industry
2	hen hen	m m	Elementary/Secondary	(0-12)	College	(1-4or 5+)									
Ż	lled v tygie her t		12 17. Father's Name (First,	Middle Last			Prope	erty M	lana	~		/Cime Mindel		ederal Go	ov.
Maryland 21215-0036	d ta b	Be		WIGGIE, LASI)									e, Maide	en Surname)	
Ž	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 is marked other than "natural", or iteme 23s or 28s-1 show other treumatic event, the Medical Examinar must be notified at	မ	Alan Smith  19a. Informant's Name/R	elationship (	Tuna Print)		10b Mailie	a Address	(Stroot o	Mary			has City	or Town, State, 2	7in Codel
∑	alth an 27 is or		Polly J. Kyl												zip Code)
ō,	1 and Health Iem 27 other tr		20a. Method of Dispositio		ignter)	20b. F	Place of Dispo	sition (Name	пıl.	L Ka I		en, Co		U682U Location - City or	Town, State
no	Pages nent of I int: If It		1 ☐ Burial 2 🗓 Cre	mation 3		JIAIO				1				•	
altimore,	artme ortan Injury	- 1	4 ☐ Donation 5 ☐ 0 21. Signature of Funeral		-	вау	yview (	. Name and						-	Maryland
Ba	permit. Pages Depertment of Important: If II eny Injury or once.		)-//		//	1					Sch:	imunek	Fun	eral Hom	e of Bel Air
			23a. Part1. Enter the dis-	ease, or com	plications that	caused the deat	h. Do not ent	er the mode	of dying	Maci	Pnal. cardiac o	r respiratory	el A arrest.	ir, MD 2	Approximate
H	Discolation		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions											Interval Between Onset and Death	
	Physician /Medical		disease or condition resulting in death)	-	a. Due to	(or as a conseq		110/14	<sub>1</sub> /	///	ruvi.	100			Je Condi
	Examiner					ANAMIER	1	when	4	カ.	100	1			
		ē	Sequentially list condition if any, leading to immedia cause. Enter Underlying Cause (Disease or injury	is, ite	b. Due to	(or as a conseq	uence of):	7 7 10	1	/ / / v	11/1/3	7			
D	outed d ansit	Examiner	Cause (Disease or injury that initiated events	1	C	,		,							
ó	exection and and artical-tr		resulting in death) Last	- 1	Due to	(or as a conseq	uence of):							1	
8760,	death certificate be executed e ettending physicien and id for use as the burial-transit	dical		•	d										
Ö	ng pt	Ned	IF FEMALE:	-			=10=0:	-							
Вох	eath certific ettending p for use as	Physician/Me	23b. Was decedent pregi			itcome of pregna birth 2 ☐ Feta		Ectopic pre	onancy					23d. Date of del	
		Sici	in the past 12 month	15 ?		nant at time of d		Other (spe						Month	Day Year
о. О	law requires that the de es been signed by the e 2 should be detached i	Phy	9 Unknown									T			
Ś	res tha igned be det	è	Part II. Other significant	conditions c	ontributing to o	leath but not res	ulting in the ur	nderlying ca	use give	en in Part I.		23e. Did	0	_	the cause of death?
oro	v require been sig should t	ted										1/2	Yes	2 □ No 3 □ Pr	obably 4 Unknown
Vital Records,	e law hes b	Completed											psy	prior to	utopsy findings available completion of cause of
<u> </u>	age Th	S										peri 1 ☐ Yes	ormed?	death? to 1 ☐ Yes	2 🗀 No
Zita Zita	Attending Physician: The r death. ector: After this certificete hiby the funeral director, page	Be	25. Was case referred to examiner?	medical	University to				Van			Check only	one		
	Physic this c	5	1 Yes 2 No				ER/Outpatien		A Othe	ar: 4 □ Nur				6 ☐Other (Spe	cify)
Ž	Jing J After funer	0		Pending		of Injury oth, Day Year)	28b. Time of Injury		C. Injury			8d. Describe	how inj	jury occurred	
<u>s</u>	death. ctor: A y the fu	cat	2 Accident 3 Suicide 6 □	investigation Could not be		a of lainer. At he		М		res 2 □ N		104 1	/Ca 1		-10
Division of	5 g g g	Certification:	4 Homicide	determined	build	e of Injury - At ho ling, etc. (Specif	y)	eet, ractory,	опісе		'	City or To	wn, Sta	ite)	ural Route Number,
_	Hospital		29a Certifier 1 💢 (	Certifiving Ph	vsician: To th	e hest at my kna	wheten chart	- innument a	t the tim	u tato acc	trilace a	ad due to the	caus.	(s) and manner as	etatud
	o the Hospital or Ai lihin 24 hours after of the Funeral Direct impletely filled in by	edicai	(Check only 2/1)	ledical Exam	niner: On the l	pasis of examina	ition and/or inv	estigation, i	in my op	pinion, deat	h occurre	d at the time	, date a	nd place, and due	to the cause(s)
	To the vithin 2 To the complet	Me	29b. Signature and title of	certifier				29c.	License	number			29d. D	ate signed (Mont	h, Day, Year)
	> - 0		► KIN	- N	17			T	) ?	465	2		Ju	132	007
			30. Name and address of	erson who	completed cau	e, of death ten	n 23a) (Type.	Print)₄	)	, , ,		Ge :	- 67	, 4 5	22 121112-1216
	b		Scoll	141	ISWIT	/ 2	Buch	Au	NU	1 3	11:	100	m	14 1601	1 21014
	Sta	te	31. Date filed (Month, Da			gistrar's Signa		P. 10	,					1	
	Registr	ar	JL	IL 0 6	2007	lerion.	D. A	DEACL							
							-								

		-	State State Registrar	of Maryland / Depa	artment of Health tificate of Deat		al Hygiene Reg. No	21111/	21684				
			Decedent's Name (First, Middle, Last)				te of Death	v Year	3. Time of Death				
	Physicia		Curtis Brian Concan	non		_		9, 2007	3:00 A M				
	/Medic Examin		4a. Facility Name (If not institution, give street and		4b. City, Town, or Location	on of Death	40	. County of Deat	h				
		•	75 Chelmsford Road		Middle	River		Baltir					
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Und Months Days Hours	s Min. (Mo	te of Birth onth, Day, Year)	9. Birt	hplace (State or Foreign untry)				
	Director		212-15-2414 <sup>1</sup> ⊠™ <sup>2</sup> □F	20 Yrs.		No	v. 6, 19	986 M	laryland				
	p v	.	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	cation				10d. fnside City Limits				
	of 2 should be filed within 72 hours after death with the Marylan and Mental Hygiene.  77 is marked other then "natural; or items 23s or 28s-f show traumatic event, the Madical Examinar must be nutilised at	5			TTI ' . M1				1 ☐ Yes 2X No				
	the N	Director	Maryland Baltimore  10e. Street and Number		White Marsh	<u>l</u>	10g. Ci	tizen of What Co	ountry?				
	with with			o Dood	21162	2		U.S.	Δ				
	leath	era			Was Decedent of Hispanic f Yes, specify Cuban, Mexi		es or No-	14. Race - Ame	nican Indian,				
(0	r Her	Funeral	1 X Never Married 2 Married 1 Ye	s 2 🕅 No			etc.)	Black, Whit	e, etc.				
ဗ္ဗ	hours after death with the Maryland turst', or Items 23a or 28a-f ehow at Exoniner must be notified at	by	3 ☐ Widowed 4 ☐ Divorced If Yes. Year o	Give or Dates:	1 ☐ Yes 2 X No Spec	orty:		Specify:	√hite				
2-0	72 ho	Completed	15. Decedent's Education (Specify only highest grade complete		dent's Usual Occupation kind of work done during m	nost of working	16b. k	(ind of Business	Industry				
2	ithin	npie		e (1-4or 5+)	DO NOT use retired)			*****	•				
2	ygier ygier t.		12		Apprentice	other's Name (First	Middle Maide	HVA(	<i>.</i>				
ם	be fill d oth	Be	17. Father's Name (First, Middle, Last)		16. MC	Melissa							
3	ould I Mer narke	T <sub>o</sub>	Greg J. Concannon  19a, Informant's Name/Relationship (Type, Print)	10h Mailie	ng Address (Street and Nur				Zin Code)				
Maryland 21215-0036	12 st h and 7 is n traun				nelmsford Roa								
	tea tea ther	( )	Melissa Zielinski (Mot 20a. Method of Disposition	20b. Place of Dispo	sition (Name of	Date		ocation - City or					
JO.			1 ☐ Burial 2 【XCremation 3 ☐ Removal fro 4 ☐ Donation 5 ☐ Other (Specify)	om State Bayview (	natory or other place)	07/05/20	007 Ra1	timore	Maryland				
Baltimore,	필본원급 .		21. Signature of Funeral Service Licensee		2. Name and Address of Fa		_						
Ba	Depa Impo any i		Bui all		705 Belair Ro								
			23a. Part1. Enter the disease, or complications the	at caused the death. Do not ent	er the mode of dying, such	as cardiac or resp	iratory arrest,	1	Approximate Interval Between Onset and Death				
	Pnysician		Immediate Cause (Final disease or condition assesser or condition as Self-inflicted Guns hot wound to head										
	/Medical		regulting in death)	to (or as a consequence of):									
	Examiner		Sequentially list conditions,  b. Due to (or as a consequence of):										
	sit ad	ine	if any, leading to immediate Due cause. Enter Underlying Cause (Disease or injury	to (or as a consequence of):									
8.	ate be executed hysicien and the burial-transit	Examiner	that initiated events c.	to (or as a consequence of):									
8760,	be ey												
387	at y di	dic	d										
9 x	eath certific attending p for use as (	/W		outcome of pregnancy				23d. Date of de	livery				
Вох	The law requires that the death certific the has been signed by the attending page 2 should be detached for use as:	Physician/Medical	in the past 12 months?	regnant at time of death 5	□Ectopic pregnancy □ Other <i>(specify)</i>			Month	Day Year				
P.O.	at the de by the	hys	9 ☐ Unknown	nknown									
	res that igned to be det	by P	Part If, Other significant conditions contributing to	to death but not resulting in the u	inderlying cause given in Pa	art I. 2	3e. Did tobacco	use contribute t	o the cause of death?				
5 S	w require been sig should b	ed					1 ☐ Yes 2	2 □ No 3 □ P	robably 4. Unknown				
of Vital Records,	aw requis been 2 should	Completed				2	4a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of				
ž	The lav	E				1	performed? ☐ Yes 2 N	death?					
ital	ysicien: Th is certificate director, pag	Bec	25. Was case referred to medical examiner?		26. P	Place of Death (Che	ock only one)		se the se				
<b>&gt;</b>	<b>8</b>	일		☐ fnpatient 2 ☐ ER/Outpatie		Nursing Home	5 🗆 Residence	6 Other (Spi	ecity) Hether's				
0 0	on o o o		27. Manner of Death 28a. D 1 □ Natural 5 □ Pending (//	ate of Injury Wonth, Day Year)  28b. Time of Injury	Work?	1 50	Describe how inj	ury occurred	hotwound				
Sio	death. ctor: A y the fu	cati	2 Accident investigation	29,2007 300 A	M 1 Yes 2	2 NO	To head						
Division	for Att	Certification:	4 Homicide determined b	face of Injury - At home, farm, st uilding, etc. (Specify)	reet, factory, office			10) 73 Che	Instantal				
	ospital of hours elunerei D			to then'S Itame of the best of my knowledge, deal	th occurred at the time, date	b bne englabas er	de River	-	l le Z				
	To the Hospital or Attending within 24 hours elter death. To the Funeral Director: After completely filled in by the funer	Medical	(Check only 2 Medical Examiner: On the	ne basis of examination and/or in manner stated.	evestigation, in my opinion,	death occurred at	the time, date a	nd place, and du	e to the cause(s)				
	To the Hi within 24 To the Fi complete	Me	29b. Signature and title of certifier		29c. License numb	ber	29d. D	ate signed (Mor	th, Day, Year)				
		/	I hatter MAD Do	put	0186	67	Ju	146.20	507				
	2	-	30. Name and address of person who completed	7 (- 11	11:11/-1	1/	1 11	771	700				
	_		31. Date filed (Month, Day, Year)	D (e (rimbie) 12. Registrar's Signature		4 THENDI	12/1	2 < 11	713				
	St: Regist	ate rar	111 0 6 2007	2. Registrar's Signature	bartes								
	**		1111 0 0 2001	Post party very	·								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) SR Month 93y 2<sup>Y</sup>0007 1:00pM CHIN 104N 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) n/a Baltimore 51 N. Wheeler Avenue If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days Hours 1**∑**M 2□F Yrs. 5-25-1948 59 MD 213-52-2788 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 ☑ Yes 2 ☐ No Baltimore 10f. Zip Code MD 10g. Citizen of What Country? 10e. Street and Number 21223 USA 51 N. Wheeler Avenue 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify: African-1 Never Married 2 Married 1 ☐ Yes 2√2 No Specify 3 Widowed 4 Divorced American 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Self Employed College (1-4or 5+) Elementary/Secondary (0-12) Maintence Tech 12th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Betty Mae Johnson Edward Chin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21244 19a. Informant's Name/Relationship (Type, Print) Ex-Windsor Mill, Wife 3505 Lynn Haven Drive, Sandra Chin-Bridges/ 20a. Method of Disposition

1 Derial 2 DCremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 7/10/07 Balto. MD Sonation 5 Other (Specify) Crematory Metro 22. Name and Address of Facility mature of Funeral Service Licens Rd., Randallstown, 9200 Liberty Part 1. Enter the disease, or complications that used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Immediate Cause (Final disease or condition resulting in death) Due to for as a consequence of) a Co d. Date of delivery Month Year Day contribute to the cause of death? 3 Derobably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

Physician /Medical **Examiner** 

**Physician** 

Examiner

**Funeral** 

Director

ral, or items 23a or 28e-f ehow Evanings must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or item any njury or other treumatic event. I'm Meulcul Evatic rat. once.

Baltimore, Maryland 21215-0036

Director

by Funeral

Completed

Be

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with the Maryland

death

/Medical

anding physicien and use as the burial-transit within 24 hours after death.

To the Funerel Director: A completely filled in by the fu

or Attending Physicien: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

Hospitel

To the

		Cornery o many Orean	- A								
Completed by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):  Due to (or as a consequence of):									
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23d. Date of delivery Month Day									
ompleted by Ph	Part II. Other significant conditions con	DAL O C . O									
Be	25. Was case referred to medical examiner?	26. Place of Death Check onl on despital:  1   Inpatient   2   ER/Outpatient   3   DOA   Other   4   Nursing Home   5   Hospital:									
Certification: To	27. Manner   eath   1   tural   5   Pending   2   Accident   investigation	28a. Date of Injury (Month, Day Year)  28b. Time of Injury M  1   Yes 2   No									
Certifica	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street, factory, office City or Town,	eet and Number or Rural Rou State)								
edicai (	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) at 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and manner stated.										

Number or Rural Route Number,

29b. Signature and title of certifier

ace, and due to the cause(s)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8021 TRIAC - 1 31. Date filed (Month, Day, Year)

State Registrar

07-05064	
William Collins	

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		- For State	tato of Many		Certific	ate of	Death		, ,	R	eg. No. 2	0.07	2   68
Physiciar		1. Decedent's Name (First, Mid-								. Date of Dea Month	Day Ye		Time of Death
ledical Examin			llins					1		July 2, 20	07 4c. County	of Dooth	1910 hrs
	1	fa. Facility Name (if not institut St. Agnes Hospital	on, give street and n	umber)			b. City, Town, or Baltimore	Location o	Death		Ba1	imo	
Funeral	7	5. Social Security Number	6. Sex	7. Age (	n yrs. last bir	thday)	If Under 1 Yea  Months Days		r 24Hrs. Min.		rth(MM/DD/YYY	7) 9. Birth; Foreign	
Director		217-70-1290	1 <u>XX</u> M 2 F		49	Угѕ.	Montals Days	Hours	IVIII.	7/23	/1957	Coun	Md.
,		Usual Residence of Decedent  10a, State 10b, Count		110	c. City, Town	or Location	on.	_				1	Od. Inside City Limits
and show any	ļ		/   / A	1		timo							1 X Yes 2 No
Maryland 28a-f show d at once.	Director	10e. Street and Number					10f. Zip Code	-			10g. Citizen of W	hat Countr	ry?
h the M 3a or 2	=	3120 Piedmo	nt Avenu	ıe			212	16		1	JSA		
s 2	era	11. Marital Status 1 X Never Married 2	12. Was De		er in U.S.		Decedent of His es, specify Cubar					e - America te, etc.	an Indian, Black,
er deat	Fune		1 Yes		No	1	Yes 2X No	specify:			Specify:	Blac	ck
n in	핡	15. Decedent's Education (Sp	or Dates:		eted) 16a	Decedent	's Usual Occupa	tion (Give			16b. Kind of B		
72 hou n "nai	ë	Elementary/Secondary (0-12	College	1-4 or 5+)	,	during mo	ost of working life	e. DO NOT	use retire	ed)			
21215-0036 nuld be filed within 72 hou Mental Hygiene. marked other than "nat e event, the Medical Exa	Completed	12				Disa	bled			e:	Never		ked
15-C		17. Father's Name (First, Midd							,	Valla	Maiden Surnam	e)	
212 Ild be Mental narke	o Be	William H.  19a, Informant's Name/Relatio			19	9b. Mailing	Address (Stree				mber, City or To	wn, State,	Zip Code)
MD ;	$-\tau$	Leroy Wallac							Ave	enue,			Md.21215
e, N 1 and 1 and Health item	Ī	20a. Method of Disposition		Chada		of Dispos	ition (Name of ce	emetery,		Date	20c. Location	- City or T	own, State
imore, MD 2 Pages 1 and 2 shoul ment of Health and b tant: If item 27 is rr	-	1 Burial 2 X Cremati 4 Donation 5 Other		ITOITI State	Met		remato						le, Md.
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical	t	24. Signature of ∓uperal Servi		1	50	22, N E.S	ame and Addres	s of Facility Othe	rs 1	Funer	al Home timore	e, PA	
	1	23a. Part I. Enter the disease,	Magnifications that		e death Dou	13	00* Eut	aw P	lace	e, Ba1	timore	Md.	21217 Approximate Interval
Physician M-dical		failure. List only one cau	se on each line.			lot enter ti	le mode or dying	, 3001 03 0	araide or	roop natory a			Between Onset and Death
Examiner		Immediate Cause (Final disea or condition resulting in death							_				
		Sequentially list conditions,	b									_	
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\d\ _ =	Examiner	(Disease or injury that initiated events resulting in death) Las	D 4 . (	a conseq	uence of):								
recuted and ransit			d										
rial rial	Medical	XUNPENDED			,prME,go		/27/07 TT				23d. Date	of delivery	
8760 tificate b ng physicas the bu		IF FEMALE: 23b. Was decedent pregnant in past 12 months?	tho	s, outcome birth	e of pregnanc	_	tal death 3	Ectopi	c p <b>regn</b> ar	псу	Month		ay Year
Box 687 death certificate at the attending ped for use as the	Physician	1 Yes 2 No 9	Inknown Hea		me of	5 Ot	her (Specify)				280		
D.O. BC that the de- ned by the a detached fo		Part II. Other significant con	9 011	to death	but not result	ing in the t	ınderlying cause	given in P	art I.	23e. Did	tobacco use cor	tribute to t	he cause of death?
i, P.O.	ģ	Human-immunoo								1 Y	es 2 No	3 Prob	ably 4 🗸 Unknown
ds, require	Completed by									24a. Wa	s an 24b		opsy findings available ompletion of cause of
COI e faw e has l	g									per	formed?	death?	_
II Re in: Th rtifical for, pa	ပ္ပို	25. Was case referred to med	ical				26.Plac	e of Death	(Check c				
Vita ysicia this ce	To Be	examiner? 1 Yes 2 No	Hospital:	Inpatien	t 2 🗸 ER/			Other <sub>4</sub>		g Home 5	Residence 6		:
ing Pt	i.	27. Manner of Death  1 X Natural 5 D	(Mo	te of Injur hth, Day,Ye		. Time of		ury at Wor	_	28d. Describ	e how injury occi	ırred	
ivision or Attend after death. Director:	atic		ending vestigation		A	· · · · · · · · · · · · · · · · · · ·		Yes 2		20f Location	(Street and Nur	her or Ru	ral Route Number, City
Division of Vital Records, tal or Attending Physician: The taw requir rs after death.  al Director: After this certificate has been sited in by the funeral director, page 2 should the funeral director for the funeral director	Certification:	d	ould not be etermined (Specific		iry - At nome,	tarm, stre	et, factory, office	bullarig, e	ic.	or Town		iber of Rai	ar Note Namber, Only
Division of Vital Records, P.O. Box 687. To the Hospital or Attending Physician: The law requires that the death certify within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	ဦ	29a. Certifier 1 Certifying	Physician: To the b	est of my	knowledge, o	leath occu	rred at the time,	date and pl	lace, and	due to the ca	use(s) and manr	ner as state	ed.
the of the complete	Medical	one) 2 Medical E	xaminer: On the bas and manne	s of exam	ination and/o	r investiga	tion, in my opinio	on, death o	ccurred a	t the time, da	te and place, and	d due to the	e cause(s)
C 5358	₩.	29b. Signature and title of cer	tifier	1				nse numbe	r		ļ		nth, Day, Year)
100 K		Calicel	10/		2		0.0	C.M.E.			July 3, 20		
18 Mayor		30. Name and address of per	Assistant Med				nn Street, Ba	Itimore	MD 21	201			
4 h	ote	Zabiullah Ali, M.D.  31. Date filed (Month, Day, Ye			s Signature		Otreot, Da						
St Regist	ate rar				K A	board							
DHIVIH 17 Rev 1/2	001	TIME	1.00		6	RIGINA	4						

OCME 2006

07-04983 Lynette J. Charles

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	Certificate	of Death		g. No.	
Physicia	in/	Decedent's Name (First, Middle,Last)	01. 1		Date of Death     Month	n Day Year	3. Time of Death
Medical Examin	ner	4a. Facility Name (if not institution, give street and no	Charles	4b. City, Town, or Location of D	June 30, 2	4c. County of Death	1047 hrs
		Howard County General Hospital	inder)	Columbia	Jean I	Howard	
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday	'		h(MM/DD/YYYY) 9. Bir	
Director	1	259-31-0/87 1_M 2×F	45	Yrs. Months Days Hours	Min. Atober	- 23,1961 Foreign	ountry CRECIA
alphanes and constrained the alphanes on		Usual Residence of Decedent					
ом апу		10a. State 10b. County	10c. City, Town or Lo	, ,			10d. Inside City Limits  1 Yes 2 No
Maryland 28a-f show at once	į	Maryland Howard		10/umbia	110	g. Citizen of What Cou	
ith the Maryland 23a or 28a-f she notified at once	Director	10614 August Ligh	it	2104	4	CLS,	
after death with the Maryland al", or items 23a or 28a-f she mer must be notified at once	Funeral	11. Marital Status 1 Never Married 2 Married Armed F 1 Yes	cedent Ever in U.S. 13. orces?	Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, P		14. Race - Amer White, etc.	ican Indian, Black,
	by F	3 Widowed 4 Divorced If Yes, Give Ye or Dates:	ar 1	Yes 2 No specify:		Specify: 13	lack
hours natur		15. Decedent's Education (Specify only highest gra	dunn	dent's Usual Occupation (Give king most of working life. DO NOT us		16b. Kind of Business/	Industry
36 iin 72 han "	Bet	Elementary/Secondary (0-12) College (	1-4 or 5+)	Counselor		0	1
21215-0036 uld be filed within 72 h Mental Hygiene. marked other than "n e event, the Medic at E	Completed	17. Father's Name (First, Middle, Last)			Name (First, Middle, M		ecreation
21215-( uld be filed v Mental Hyg marked oth	Be (	Boosevelt Rob	inson	Fan	ne Mae	Thurse	ond
	٩	19a. Informant's Name/Relationship (Type, Print )		ailing Address (Street and Number	er or Rural Route Num	ber, City or Town, State	e, Zip Code)
re, MD s 1 and 2 sho of Health and If item 27 is		Roland W. Charles 11	usbard 106	position (Name of cemetery,	ight Co	lumbia, M	15 21099
nore, MD ; sges I and 2 sho. tt of Health and I t: If item 27 is to other traumatic		1 Burial 2 Cremation 3 Removal f	oromoton, o	E other place)			
F a a a a		4 Donation 5 Other Specify:	Crownsi	Ville Vet - Cen- 2. Name and Address of Facility	1/10/07	Crownsvi	lle, MD
Balti permit. Departin Import injury		21. Signature of Funeral Service Licensee		4210 Belay R		-Harns H	
Physician		23a. Part I. Enter the disease, or complications that of failure. List only one cause on each line.	aused the death. Do not ent	ter the mode of dying, such as care	diac or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and
/Medical Examiner	1		ary thromboembol:	ism			Death
		b Deep ve	a consequence of): ein thrombosis				
	Jer	If any leading to immediate Euro to for as	a consequence off:				
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	a consequence of):				
uted nd ransit	ă	events resulting in death) Last Due to (or as d.	2 00/100400/100 0//				
760, cate be executed physician and he burial - transit	Medica	X UNPENDED AMENDED	,PII,27,perME,g8	70 8/8/07 TT			
	-	IF FEMALE: 23c. If yes,	outcome of pregnancy	70, 0/0/0/ 11		23d. Date of deliver	У
certif	cian	23b. Was decedent pregnant in the past 12 months?	birth 2 nant at time of death 5	Fetal death 3 Ectopic p	regnancy	Month	Day Year
Box 68' e death certifi the attending ed for use as:	Physician	1 Yes 2 No 9 V Unknown g Unknown	3	Other (Specify)			
Ç € £ €		Part II. Other significant conditions contributing	•	he underlying cause given in Part	I. 23e. Did to	bacco use contribute to	the cause of death?
S, P.C. uires that signed l d be deta	ed by	Ruptured subcapsular hep	atic hematoma		1 Yes	2 No 3 Pro	bably 4 🗹 Unknown
of Vital Records, In Physician: The law requir After this certificate has been s neral director, page 2 should t	Completed				24a. Was a autop:	sy prior to	utopsy findings available completion of cause of
Rec The la cate hi	E				perfor		es 2 No
tal Recian: The	Be	25. Was case referred to medical examiner?		26.Place of Death (C			
on of Vital   ending Physician: anh. or: After this certif the funeral director,	ပ	1 Yes 2 No Prospital 1	Inpatient 2 ✓ ER/Outpate of Injury 28b. Time			Residence 6 Othe	er:
- <u>-</u> - ~ 2	io :	1 X Natural 5 Pending	h, Day,Year)	1 Yes 2 N		low injury occurred	
Division tal or Attendir rs after death. al Director: A	icat	2 Accident Investigation 28e. Pla	ce of Injury - At home, farm,	street, factory, office building, etc.		Street and Number or R	ural Route Number, City
Div	Certification:	Suicide 6 Could not be determined (Specify			or Town, S		
Division  To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Physician: To the be		ccurred at the time, date and place			
Fo the within Fo the	Medical	one) 2 Medical Examiner: On the basis and manner	of examination and/or inves stated.		rred at the time, date		
	Ž	29b. Signature and title of certifier	161	29c. License number		29d. Date signed (Mo	onth, Day, Year)
0		NVI. /		O.C.M.E.		July 1, 2007	
01		30. Name and address of person who completed cau Jack Titus MD. Deputy Chief Medi		Penn Street, Baltimore, M	D 21201		
91	ate	31. Date filed (Month, Day Year) 32. F	te strar's Signature				
Regist		1111 0 6 2007	Clerence St.	Sports			

07-05007

aul Comish		State of Maryland / Department of Health and Mental Hygiene  1- For State Registrar  Certificate of Death  Reg. No.	2168
Physicia Jedical Exami	ın/	1. Decedent's Name (First, Middle, Last)  2. Date of Death  Name (First, Middle, Last)	me of Death 233 hrs
neuicar Exami	ler	4a. Facility Name (if not institution, give street and number)  CORNISH  June 30, 2007  4b. City, Town, or Location of Death  4c. County of Death	200 1115
		Johns Hopkins Hospital Baltimore City N/A	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)    Foreign Country   Funder 24Hrs.   Foreign Country   F	MARYLAND
, any	ŀ	10a. State 10b. County 10c. City, Town or Location 10d.	Inside City Limits
Maryland 28a-f show any d at once.	ģ	MARYLAND N/A BALTIMORE CITY 106. Street and Number 100f. Zip Code 10g. Citizen of What Country?	Yes 2 No
the Mar or 282	Director	S20 N BELVORN AVENUE 21205	
death with the Maryland or items 23a or 28a-f sho must be notified at once	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American In White, etc.	ndian, Black,
fter dea			nv
hours a natura	ed by	15 Decedent's Education (Considerable Industrial Action Proposed Industrial Industria	
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f shraif event, the Medical Examiner must be notified at once	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)  FORK LIFT DRIVER VICTOR GRAF	HICS INC
21215-0036 uld be filed within Mental Hygiene. marked other that r event, the Medics			- 1
212 ould be I Menta marke ic event	To Be		Co (a)
M alth 2 ma 2 raum	3	CHARRETTA TAYLOR (5/5/TER) 10/2 EVESTAM AVE. SALTHORE W. 2  20a. Method of Disposition   20b. Place of Disposition (Name of cemetery,   Date   20c. Location - City or Town	12 12
Baltimore, M permit. Pages 1 and 2 Department of Health Important: If item 2		1 Burial 2 Cremation 3 Removal from State crematory or other place)	LIADUIAA/A
Baltimo permit. Page Department of Important:		4 Donation 5 Other Specify: WOODLAWN CEMETERY 0'-09-01 WOODLAWN, 21 Signature of Funeral Service Licensee 22 Name and Address of Facility 3R0 WARDLAWN TR. FUNERAL	HOME
ம் ஆத்.த்.த் Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Ap	2/2/7 proximate Interval
/Medical			etween Onset and Death
Examiner		or condition resulting in death)  Due to (or as a consequence of):	
	ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause	
d d	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
50, te be executed ysician and	ledical E		
760, cate be physici the buri			
Box 68760 he death certificate b r the attending physined for use as the bu	ician	Day Secretary pregnant in the past 12 months?    1   Live birth   2   Fetal death   3   Ectopic pregnancy   Month   Day	Year :
D. Bo t the deal by the al	Physician/	Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the ca	ause of death?
P.C es that igned be deta	ð	1 Yes 2 ✓ No 3 Probably	4 Unknown
of Vital Records, P g Physician: The law requires th the this certificate has been signs neral director, page 2 should be d	Completed	24a. Was an 24b. Were autopsy prior to comple	findings available etion of cause of
ician: The la certificate h	S	performed? death? 1 ✓ Yes 2 No 1 ✓ Yes	2 No
Vital ysician his cert directo	o Be	m examiner? Hospital: 4 hospit	
	on: T	27 Manner of Death 29c Date of Injury 29c Time of Injury 29c Injury at Wark? 29d Describe how injury accurred	
Division tal or Attendi rs after death at Director: A	ertification:	2 Accident Investigation   3 Suicide 6 Could not be   28e. Place of Injury - At home, farm, street, factory, office building, etc.   28f. Location (Street and Number or Rural	
Div the Hospital or hin 24 hours afte the Funeral Diu	Cert	3 29a Cartifiar	
DIV To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical	To Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause (s) and manner as stated.	se(s)
T W. i	Me		lay, Year)
		James Jeg War O.C.M.E. July 2, 2007	
3		30. Name and address of person who complicated cause of death (Item 23a)  Tasha Greenberg MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
St Regist	ate rar		
DHMH 17 Rev 1/2		- FERRISE DE PROPERTIES	

07-04993 Sterling China Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2007 21689

ŭ		1- For State Registrar	Certificate of D	eath		j. No.	1 4,00
Physicia Medical Exami	an/	1. Decedent's Name (First, Middle, Last)	0.11		2. Date of Death Month	Day Year	3. Time of Death 1350 hrs
/ledical Exami	ner	_STERLING	CH	NA	June 30, 20		
		4a. Facility Name (if not institution, give street and number) Sinai Hospital		City, Town, or Location of Death altimore	1	4c. County of Death	NIA
Funeral				F Under 1 Year If Under 24Hrs	8. Date of Birth	(MM/DD/YYYY) 9. Bir	
Director		216-72 - 4068 1XM 2 F	_	Months Days Hours Min	—	Foreig	
. Substitution of the subs	eine femige		10c. City, Town or Location				10d. Inside City Limits
8	_	MARWAIN ALLA		RAITIM	DE (	7,71	1 XYes 2 No
ith the Maryland  23a or 28a-f show	Director	10e. Street and Number	10	Of. Zip Code	100	g. Citize of What Cour	I
he Mi or 2	i e	HALL BARRAIN AV	EALLIE	21215		116	Λ
with t		11. Marital Status 12. Was Decedent B	Ever in U.S. 13. Was D	ecedent of Hispanic Origin? ( S	pecify Yes or No-	14. Race - Ameri	ican Indian, Black,
leath ritem	Funeral	1 Never Married 2 Married Armed Forces?	No If Yes,	specify Cuban, Mexican, Puerto	Rican, etc.)	White, etc.	
after death with the Maryland al", or items 23a or 28a-f sh iner must be notified at once	by F	3 Widowed 4 Divorced If Yes, Give Year		s 2 X No specify:		Specify: B	LACK
	d b	15. Decedent's Education (Specify only highest grade comp	oleted) 16a. Decedent's U	Jsual Occupation (Give kind of of working life. DO NOT use ret		16b. Kind of Business/	Industry
6 n 72 h an "n	Jete	Elementary/Secondary (0-12) College (1-4 or 5	+)		iled)	0	10
5-0036 led within 72 Hygiene other than the Medical	Completed	11"GRADE	LAE	BORER		CONSTRUC	TION (O.
## 를 포 등 및 I	Be C	17. Father's Name (First, Middle, Last)	0111110	18.Mother's Name	e (First, Middle, M	aiden Surname)	10.1
D 2121 should be fill and Mental B 7 is marked	To B	19a. Informant's Name/Relationship (Type, Print )	19b. Mailing Ad	dress (Street and Number or	Rural Route Numb	per City or Town State	Zin Code)
and 2 shou lealth and N		ALICE CHINA (MOTH	- F. 100	OLD COURT RI	AOT TO		CKUN MD. 21133
re, ME s 1 and 2 s of Health ar If item 27 her trauma		20a. Method of Disposition	20b. Place of Disposition	(Name of cemetery,	Date	20c. Location - City or	
nore ages 1 at of H at: If i		1 Burial 2 X Cremation 3 Removal from Sta		MATORY 07-	12-17	BALTIN	ID- MA
Baltimore, permit. Pages 1 a Department of He Important: If ite		4 Donation 5 Other Specify: 21. Signature of Funetal Service Licensee		e and Address of Facility	RAUNI =	TO FULL	RE, IID
B P P E		- MANDUM	<u> </u>	TEND FULL	ONAVE	BALTO	MD 21217
Physician	(	23a. Part / Enter the disease, or complications that caused t fajlure. List only one cause on each line.	he death. Do not enter the n	node of dying, such as cardiac	or respiratory arres	st, shock, or heart	Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease a. Cocaine and	d tramadol intox	ication			Death
		or condition resulting in death)  Due to (or as a conse	quence of):				
	er	Sequentially list conditions, if any, leading to immediate b. Due to (or as a conse	quence of):				
	Examiner	(Disease or injury that initiated c					
lmsit de /	EXa	events resulting in death) Last Due to (or as a consert d.	quence of):				
760, cate be executed physician and he burial - transi	edical						
760, icate be physicia the buria	Med	#23a,2/,28a IF FEMALE: 23c. If yes, outcom	n-f. perME.g869.	7/13/07 TT		23d. Date of deliver	<u> </u> v
		23b. Was decedent pregnant in the past 12 months?	2 Fetal o	death 3 Ectopic pregn	ancy		Day Year
Box 68; e death certifi the attending ed for use as t	sici	1 Yes 2 No 9 Unknown 9 Unknown	ime of death 5 Other	(Specify)			
D. Boy t the deatl by the att	Physician	Part II. Other significant conditions contributing to death	but not resulting in the under	riving cause given in Part I.	23e. Did tob	acco use contribute to	the cause of death?
of Vital Records, P.O. Box 68: g Physician: The law requires that the death certificate this been signed by the attending neral director, page 2 should be detached for use as in	by			,	_	2 No 3 Prot	
ds, equire	Completed				24a. Was ar		itopsy findings available
Division of Vital Records, tal or Attending Physician: The law requir rs after death.  al Director: After this certificate has been seled in by the funeral director, page 2 should!	mpl				autops perforn	ned? death?	completion of cause of
tal Rection: The certificate ector, page		25. Was case referred to medical		26.Place of Death (Check	1 Yes 2	✓ No 1 Ye	es 2 No
Vital ysician: his certif director,	o Be	examiner? Hospital:	nt 2 🗸 ER/Outpatient 3	Othor		Residence 6 Other	r:
1 of \ding Phy.	-1	27. Manner of Death (Month, Day,Ye	y 28b. Time of Injur	y 28c. Injury at Work?	28d. Describe ho	ow injury occurred	
ion tendir eath.	ţ	Natural 5 Pending Find 6/30/		1 Yes 2 X No	lunk		
Division pital or Atten ours after death	ertification:	2 Accident investigation	ury - At home, farm, street, fa	actory, office building, etc.	28f. Location (St	reet and Number or Ru	ıral Route Number, City
Dispital cours a filled	Cert	4 Homicide determined (Specify) fo	und at home		4011 Boarn	ate) Man Ave. Balt	imore, MD
Divisior  To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Physician: To the best of my one) Certifying Physician: To the best of my Medical Examiner: On the basis of exam					
To t With To t	Medical	and manner stated.  29b. Signature and title of certifier		29c. License number		29d. Date signed (Mo	
		(	4	O.C.M.E.		July 1, 2007	,
OF		30. Name and address of person who completed cause of de	eath (Item 23a)				
المها		Jack Titus MD. Deputy Chief Medical Ex		Street, Baltimore, MD 2	1201		
		31. Date filed (Month, Day, Year) 32 egistrar	s Signature				
Regis	Tell	JUL U U LUUI RIEMELEE	ST COMMON				

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Month VICTORTA COWELL В. Ju1y 2007 5:50 a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4108 Jefferson Street Hyattsville Prince George's 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🗙 F Yrs 02-06-1948 Director 59 North Carolina 239-78-1428 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Mark al Examiner must be notified at 1 X Yes 2 □ No Director Hyattsville Maryland | Prince George's 10f. Zin Code 10g. Citizen of What Country? 10e. Street and Number 4108 Jefferson Street 20781 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. illed within 72 hours after 1 ☐ Yes 2 💆 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2K No Specify: White <u>م</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry District of Columbia Elementary/Secondary (0-12) College (1-4or 5+) Chaplain St. Elizabeths Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 12 should be fi h and Mental H 7 Is marked ot Henry Alton Brannan Mildred Dean 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 nent of Health a ant: If item 27 Is John Churchill Cowell - Husband 4108 Jefferson Street, Hyattsville, MD 20781 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Injury or permit. Page Department of Important: If any Injury or Metropolitan Crematory 07-05-2007 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia 21. Signatur of Funeral Service Licenseq 22. Name and Address of Facility 4739 Baltimore Ave. Gasch's Funeral Home, P.A. M01491 Hyattsville, MD 20781 Michelle 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic Breast Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and the burial-transit Due to (or as a consequence of) Physician/Medical as 1 attending IF FEMALE: nse s 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Į in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 2 X No the 9☐Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Brain Metastases 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown page 2 should Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has eutopsy 2∏No 1 Yes 2 No 1 TYes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Tes 2X No ို 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of ial or Attending Pi s after death. al Director: After t ed in by the funers 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 ☐ Pending investigation (Month, Day Year) Injury 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 ី Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated 29a. Certifier

Box 68760. P.0. Division or Vital Records, To the Hospital or within 24 hours at within 24 hours at To the Funeral C

15

State Registrar

Medical

Martin Weltz, MD 31. Date filed (Month, Day, Year)

wards

29b./Signature end title of certifier

(Check only

one)

weltzw.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

29d. Date signed (Month, Day, Year)

D23743

July 5, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7525 Greenway Center Drive, Greenbelt, MD 20770

32. Registrar's Signature

Been &



State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) July **Physician** Margie Bruce Criss 2007 3:50 P M /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 410 Hanna Way Bel Air Harford If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Min. Hours 1□M 21XF 72 Yrs 218-32-0040 June 27. 1935 Maryland Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 23a or 28e-f ehow 1 ☐ Yes 2 TNo Directo Maryland Harford Bel Air 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 451-4 Moores Mill Rd. 21014 USA Funerai Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 5 1 ☐ Yes 2 No Specify: Specify: r then "natural", o δ 3X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry during most of working Elementary/Secondary (0-12) College (1-4or 5+) 11 Homemaker Own Home permit. Pages 1 and 2 should be file Depertment of Heelth and Mental Hy Important: if I tem 27 1e marked ofth any Injury or other treumatic event, 9068. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Earl Edward Roe Virgie Clyde Hart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 410 Hanna Way, Bel Air, MD 21014 Robin. M. Payne / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Aberdeen, Maryland Harford Memorial Gdn 7-6-07 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. 50 W. Broadway, Bel Air, Maryland 21014 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. tmmediate Cause (Final disease or condition resulting in death) **Physician** NON SMALL CELL LUNG CANCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): ettending physician e for use as the burial-Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown been signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 5 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 105 performed? 1 Yes 2 200 2 No 25. Was case referred to medical examiner? Be the funeral director 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Yes 2 No 3□ DOA DAUGHTER, S this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how intury occurred Certification: RESIDENCE After 1-Natural 5 Pending investigation 1 Yes 2 No death. 2 Accident Director: 3 Suicide 6 Could not be determined 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide within 24 hours To the Funeral Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medicai 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dev. Year) JULY 3, 200-00058475 PHYSICIAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 602. SOUTH ATMOOD ROAD BELTER MARTLAND PHILIPHILATPUNIN 2-1014 32 Registrar's Signature 31. Date liled (Month, Day, Year) (cole State JUL 0 6 2007 Barre 1 Registrar

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State of Maryland /	Department of Health and Mental Hygi	en

TWOOD Cabea	1-	- For State Certificate of Death Reg. No.
hysicia	n/ 1	Registrar 1. Decedent's Name (First, Middle,Last)  SHERWOOD ALBERT CABEAN  2. Date of Death Month Day July 3, 2007  3. Time of Death 0639 hrs
Examir		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death
		JORDS HOPKITS HOSPITAL  S Date of Birth(MM/DD/YYYY) 9. Birthplace (State or
Funeral Director		5. Social Security Number 218-46-9071 6. Sex 1218-46-9071 7. Age (In yrs. last birthday) 11218-11218 1
any	-	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
2		MD N/A BALTIMORE
Aaryland 28a-f show 1 at once	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
the Mi		516 CLINTON STREET  21205  USA  14. Race - American Indian, Black,
215-0036 he filed within 72 hours after death with the Maryland ntal Hygiene. Red other than "natural", or items 23a or 28a-f sho ent, the Medical Examiner must be notified at once.	Funeral	11. Married Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No  13. Was Decedent Gright (Opcon) 165 b. White, etc.  14. Was Decedent Gright (Opcon) 165 b. White, etc.  15. Was Decedent Gright (Opcon) 165 b. White, etc.
after c al", o	by F	3 Wildowed 4 X Divorced If 'yes, Give Year US ARMY 1 Yes 2 X No specify: Specify:  15 Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done)  16 Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done)
hours: natur		15. Decedent's Education (Specify only highest grade completed)  during most of working life. DO NOT use retired)
36 in 72 han " dical J	bet	12 CORRECTIONS OFFICER BALTIMORE CITY
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	e Completed	17. Father's Name (First, Middle, Last) ROBERT CABEAN  18. Mother's Name (First, Middle, Maiden Surname) EDITH CAREY
212' ald be: Mental marke	) B	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21 20
MD 2 d 2 shou Ith and I n 27 is 1		ANDREA MOORE / DAUGHTER 6137 MARQUETTE RD APT B BALLIMORE, MO
C 65 55 52		20a. Method of Disposition  1 XBurial 2 Cremation 3 Removal from State  MD VETERANS CEM  7/09/07 OWINGS MILLS, MD
Baltimore, permit. Pages I a Department of He Important: If ite injury or other ti		21. Signature of Funeral Service Licensee 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AV, BALTIMORE, MD
/sician		23a. Per Enter the desease, or complications that caused the death po not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart  Between Onset and
Medical		failure. List only one cause on each line.  Immediate Cause (Final disease a Narcotic (morphine) intoxication
Examiner		or condition resulting in death)  Due to (or as a consequence of):
	_	Sequentially list conditions,  if any leading to immediate  Due to (or as a consequence of):
اسييا	aminer	cause. Enter Underlying Cause
d sit		events resulting in death) Last
executed an and al - trans		
760, cate be executed physician and the burial - transif	Medical	WINDED  AMENDED  #25a, PII, 27, 28a-f, perME, g869, 7/13/07 TT  IF FEMALE:  23d. Date of delivery  AMENDED  23d. Date of delivery
1876 rtifical ing ph		
ath cer attend	Physician/	past 12 months?  4 Pregnant at time of death 5 Other (Specify)  1 Yes 2 No 9 Unknown 9 Unknown
O. Box 687 that the death certififuled by the attending detached for use as t	듄	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?
, P.O. ires that the signed by	<u>ā</u> .	
cords, law require has been si	ete	24a. Was an autopsy findings availab autopsy prior to completion of cause of
COT e law r e has t	Completed by	performed? death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
/ital Rec ysician: The l his certificate l	၂ ပိ	
/ita ysicial his cer	o Be	
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ion tendi eath.	atio	5 1 Natural 5 Pending Investigation Find 7/3/2007 FNd 6:00 am 1 Yes 2 X No unk  Accident Investigation Investigati
ivis or At after d Direc	Certification:	Accident investigation investigation at large street investigation investigation investigation and some and some and some are street investigation investigation investigation investigation and some are according to the solution of the solution investigation investigation investigation and some are according to the solution of the solution investigation investigation and some are according to the solution of the
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicial To the Funeral Law Attending Physician Provided For the Purity State of the Attending Physician Provided For the State Purity State of the State Of the State Of Sta		
To the	Medical	and manner stated. 29d Date signed (Month Day Year)
	2	O.C.M.E. July 4, 2007
		30. Name and address of person who completed cause of death (Item 23a)  Jack Titus MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201
	Stat	Sack Titus W.B. 2004 September Signature
Reg	istra	A 0 2007 Ma . // Worker
DHMH 17 Rev	1/200	ODICINAL

			For State Registrar	State of	Marylar		artment of H		nd Mental H	ygiene Reg. No.	17 2169	3
	Physici /Medic		1. Decedent's Name (First, Middle, Last Charlotte E. Curre	_					Jumphth 3,		Year 3. Time of Death 12:30 A.	
	Examin		4a. Facility Name (If not institution, give Continuum Nursing Home		ber)		4b. City, Town, o Sykesvi	11e		4c. County Carr		
	Funeral Director		213-12-0307	x ] M 2 <del>X</del> F	7. Age (In yrs. 91	last birthday) Yrs.	If Under 1 Year Months Days		Min. 8. Date of B (Month, E Februar	y 2, 1916	9. Birthplace (State or Fore Maryland	ign
	Maryland f ahow	ō	Usual Residence of Decedent           10a. State         10b. County           Maryland         N/A			ty, Town or Lo					10d. Inside City Lim 1 X Yes 2 ☐ 8	
	with the 1 3a or 28e-	I Director	10e. Street and Number 3607 St. Margaret Stre	æt	et			10f. Zip Code 21225			Vhat Country?	
036	72 hours after death with the Maryland natural', or lierne 23a or 28e-f ahow dical Examirational be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 XWidowed 4 Divorced	12. Was Deced Armed Ford 1 Tyes 2 If Yes, Give Year or Da	ces? 2 <b>K</b> ] No	1	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 X No	lispanic Originan, Mexican,  Specify:	n? (Specify Yes or N Puerto Rican, etc.)	Black	e - American Indian, k, White, etc. : White	
Maryland 21215-0036	within liene.	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)		16a. Decedent's Usual Occupa (Give kind of work done of life. DO NOT use retired		during most of working d)			6b. Kind of Business/Industry  Blazer Financial Co.		
land	should be Tiled ind Mental Hygi marked other umatic event, II	To Be C	17. Father's Name (First, Middle, Last) Charles Urban						s Name (First, Middle Mary Frantz		e)	
, Mar	12 sh h and 7 is m traum		19a. Informant's Name/Relationship (T) Philip Schruefer/Son	vpe, Print)		1624 H	leather Hei		or Rural Route Num Idersburg Ma	ryland 217	84	
Baltimore,	te ite		20a. Method of Disposition  1   □ Burial 2 □ Cremation 3 □ I  4 □ Donation 5 □ Other (Specify,			cemetery, crei t Holy F		7	Date 7/7/07		city or Town, State ore Maryland	
Bail	permit. Page Department of Important: If any injury or		21. Signature of Funeral Service Licens	illar	/						214 Approximate	
4	death certificate be executed  A stiending physicien and a stiending physicien and a stiending physicien and a stiending transit and a stiending trans	Ilcal Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	or as a consector as	quence of):		cer		allesi,	Interval Between Onset and Death	
.O. Box 6	at the death certific by the attending pl tached for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outc 1 ☐ Live bii 4 ☐ Pregna 9 ☐ Unkno		23d. Date Mor	e of delivery hth Day Year					
<u>α</u>	The law requires that I te has been signed by bage 2 should be deta	Ď	Part II. Dther significant conditions co	ntributing to de	ath but not res	sulting in the u	nderlying cause giv	ren in Part I.			ibute to the cause of death?	-
of Vital Records,		Completed							24a. Wa aut per 1 🗆 Yes	tormed?	Vere autopsy findings availa vior to completion of cause d leath? □ Yes 2□ No	bie of
Z.	Physician: ' this certifica	o Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital:	patient 2	ER/Outpatier	nt 3 DOA Ott	0.00	of Death (Check only		or (Specify)	
ion of	ling After une	atlon: T	27. Manner of Death  1  Natural 5  Pending 2  Accident investigation	28a. Date o		28b. Time o Injury	f 28c. Injui	y at	28d. Describe	how injury occurre		
Division	itel or Attend rs after death ral Director: ,	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of building	of Injury - At h g, etc. <i>(Speci</i>	ome, farm, sti fy)	reet, factory, office	28f. Location (Street and Number or Rural Route City or Town, State)		er or Rural Route Number,		
	To the Hospitel or Atte within 24 hours after de To the Funeral Direct completely filled in by the	Aedical	(Check only one)	iner: On the ba	sis of examina	ation and/or in	vestigation, in my	pinion, death		e, date and place, a	and due to the cause(s)	
)	To To con	×	29b Signature and title of certifier	neig	M.	D.	D -	005 <sup>4</sup>	+218	0 17 - 0	3-2007 July MD 21157	
_	10		DR Raman	3 Kan	of death (Iter	34°	Print) Male	olm c	dure, 1	Nertm	mity MD	
	Sta Registr		31. Date filed (Month, Day, Year) 6 2	007	gistrar's Sign	ature	harte				2113	

07-04936

ay Cooper	State of Maryland / Department of Healt 1- For State Certificate of Death	1	, No. 2007 21691					
Physician/	Registrar  1. Decedent's Name (First, Middle,Last)	2. Date of Death	3. Time of Death					
Medical Examiner	KAY LOVER COOPER	June 28, 20	007 1920 Hrs					
	4a. Facility Name (if not institution, give street and number)  719 Roundview Road  4b. City, T  Baltim	own, or Location of Death	4c. County of Death					
Funeral	7 15 Nouriew Noue		(MM/DD/YYYY) 9. Birthplace (State or					
Director		Days Hours Min.	27,1957 Country Villaginia					
	Usual Residence of Decedent	Tiagus a						
w any	10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits 1 XYes 2 No					
Maryland 28a-f show d at once.	Many and Baltimers 106, Zip	Code 10	g. Citizen of What Country?					
th the Maryland 23a or 28a-f sho notified at once	710 0 1	1225	USA					
s 23a e notifi	11. Mantal Status 12. Was Decedent Ever in U.S. 13. Was Decede	nt of Hispanic Origin? ( Specify Yes or No-	14. Race - American Indian, Black,					
r death with or items 23 must be no	Never Married 2 Married 1 Yes 2 No	y Cuban, Mexican, Puerto Rican, etc.)	White, etc					
s after or rall, or niner n	3 Widowed 4 Divorced If Yes, Give Year or Dates:	No specify:	Specify: African HINERICAN  16b. Kind of Business/Industry					
hours natur Exam	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)	Occupation (Give kind of work done king life. DO NOT use retired)	166. Kind of Business/Industry					
036 thin 72 ne. than " ledical		spation Officer	STAte 2 MARY And.					
21215-0036 uld be filed within 72 hour Mental Hygiene. marked other than "natu e event, the Medical Exan To Be Completed	17, Father's Name (First, Middle, Last)	18.Mother's Name (First, Middle, M	laiden Surname)					
1211 I be fill be fill riked vent, I	Robert Lee Cooper	MAYbelle Kand	olph					
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland hand Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f she marite event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	19a Informant's Name/Relationship (Type, rint)  19b Mailing Address  19c Address	(Street and Number or Rural Route Num	ber, City or Town, State, Zip Code)					
and 2 sho lealth and tem 27 is	20a Method of Disposition 20b. Place of Disposition (Nar	me of cemetery, Date	20c. Location - City or Town, State					
nore	1 Burial 2 Cremation 3 Removal from State crematory or other place	July 07, 2007	Lansobure, MARYLAND					
Baltimore, MD 2121 permit. Pages I and 2 should be fi Department of Health and Mental Important: If item 27 is marked injury or other traumatic event,	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and							
E P P W	Lally m. Callace 3405 W	Address of Facility on light the funeral So franklin start Bath	est, shock or heart Approximate Interval					
Physician Medical	23a, Part I. Enter the disease, or complications that caused the death. Do not enter the mode failure. List only one cause on each line.		Between Onset and Death					
/ :aminer	Immediate Cause (Final disease or condition resulting in death)  a. Atherosclerotic cardiovascular  Due to (or as a consequence of):	disease						
	Sequentially list conditions, b.							
	if any, leading to immediate  Due to (or as a consequence of):  cause. Enter Underlying Cause							
ted nsit Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):							
60, e be executed ysician and burial - transit	d. TY ANGARED 19bper fh 9869 7-6	−07 vt						
10, e be execut ysician and burial - tra	XUNPENDED X AMENDED 19bper fh g869 7-6 #23a PII 27 perME g869	. 7/13/07 TT	23d. Date of delivery					
3876 rtificat ing ph as the	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day							
). Box 6876 the death certificate by the attending phy ched for use as the? Physician/M	4 Pregnant at time of death 5 Other (Special Special	cify)						
Records, P.O. Box 6876. The law requires that the death certificate cate has been signed by the attending phy page 2 should be detached for use as the it.	Part II. Other significant conditions contributing to death but not resulting in the underlyin	g cause given in Part I. 23e. Did to	bacco use contribute to the cause of death?					
P.C es that igned be deta	Cirrhosis of the liver	1 Yes	2 No 3 Probably 4 V Unknown					
rds, requir been s hould		24a. Was autop						
Records,   The law requires ficate has been sig page 2 should be		perfor 1 ✓ Yes	rmed? death? 2 No 1 ✓ Yes 2 No					
Division of Vital Records, P.O. Box 6876. ral or Attending Physician: The law requires that the death certificate ral fater death. After this certificate has been signed by the attending phylical in by the funeral director, page 2 should be detached for use as the bentification: To Be Commisted by Physician/M	25. Was case referred to medical	26.Place of Death (Check only one)						
of Vital Physician: er this certificator,	1 ✓ Yes 2 No Impatient 2 ER/Outpatient 3		Residence 6 Other: Scene					
n of inding landing la	27. Manner of Death 1 X Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury	1 Yes 2 No	10, 11, 10, 10, 10, 10, 10, 10, 10, 10,					
isio Atten	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factor		Street and Number or Rural Route Number, City					
Division or spital or Attending hours after death meral Director: After filled in by the fune Contification:	3 Suicide 6 Could not be determined (Specify)	or Town, S	State)					
		e time, date and place, and due to the caus	se(s) and manner as stated.					
To the Ho within 24 To the Fu completel	one) 2 Medical Examiner: On the basis of examination and/or investigation, in m 29b. Signature and title of certifier 29b. Signature and title of certifier 29b. Signature and title of certifier	Ic. License number	29d. Date signed (Month, Day, Year)					
	Jan	O.C.M.E.	June 29, 2007					
40	30. Name and address of person who completed gause of death (Item 23a)  Susan Hogan MD. Assistant Medical Examiner 111 Penn Stre	et, Baltimore, MD 21201						
Stat	Loo Fillistante Circoturo	and a second sec						
Registra	1	1						
DHMH 17 Rev 1/200	ORIGINAL							

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year Physician DAULD TUL 10:05 AM 2 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BALTIMORE SECOURS 405PITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day,, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Country) Days Hours 1 M 2 □ F 218-06-3897 Director 1198 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside Çity Limits ortant: If item 27 Is marked other than "natural", or items 23a or 28a-1 show injury or other traumatic event, the Medical Examiner must be notified at 1 res 2 No Director mase 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? prmme Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or item any injury or other traument. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, grandmother 701 20b. Place of Disposition (Name of Date Method of Disposition 1 ☐ Burial 2 ☐ Cremation 20c. Location - City or Town cemetery, crematory Ballimore 3 ☐Removal from State Metro 6-07 4 ☐ Donation 5 ☐ Other (Specify) EDITH WYNN Funeral Se 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Edith Wyw MO1215 200 East Lexington ST. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 200 East Lexington ST, Suite101 Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Early Unerlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner and burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy be detached for in the past 12 months? Day Year 5 Other (specify) ☐Yes 2☐No the 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed 2 No To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No M 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2000 BaltimorE W 31. Date filed (Month, Day, Year) Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

Registrar

State

MARSH

ELISABETH
31. Date filed (Month, Day, Year)

JUL 0 6 2007

M.D.

2. Registrar's Signature

4940 EASTERN AVENUE BALTIMORE, MD 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death June 29, 2007 **Physician** JOHN ALEXANDER DeVAUGHN 9:15 A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MANORCARE OF DULANEY Baltimore County Towson If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Hours 217-24-6082 76 Feb 23, 1931 Macyland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 ☑ No Directo Maryland Baltimore County Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 618 Charles Street Avenue 21204 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 SYes 2 No 48-50 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify. Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) Project Manager Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Earl DeVaughn ု Ellen Bernadette Gilmore 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn M. DeVaughn (Wife) 618 Charles Street Avenue, Towson, Maryland 21204

ce of Disposition (Name of Date | 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/3/2007 <u>Glen Burnie, Maryland</u> <u>Glen Haven Men Pk</u> 21. Signature of Funeral Service Vibore MUTCHELL-WIEDEFELD FUNERAL HOME, INC. Martin D. Lawson 6500 York Road, Baltimore, Maryland 21212 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical

Physician /Medical Examiner

burial-transi

signed by the attending physician be detached for use as the buria

page

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Completed

Be (

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Certification:

Medical

permit. Pages 1
Department of H.
Important: If iter
any injury or oth

**Funeral** 

Director

and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygene. To Is marked other than "natural", or items 23a or 28a-f show her traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

Hospital or Attending Physician:

4 hours after death.

-uneral Director: Af
ely filled in by the fur

cause on each line.	
Lung cancer	
Due to (or as a consequence of):	
Due to /or on a concernance of	
Due to (or as a consequence or).	
Due to (or as a consequence of):	
	Due to (or as a consequence of):  Due to (or as a consequence of):

23b. Was decedent pregnant in the past 12 months? 2 ☐ No 9 Unknown

.00.	ii yes, outcome	programicy
	1 ☐Live birth	2 Fetal deat
	4□Pregnant at	time of death
	9 Unknown	

3 Ectopic pregnancy 5 Other (specify)

Month Day

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

23d. Date of delivery

Year

25. Was case referred to medical examiner?

26. Place of Death (Check only one) Other: 4 Nursing Home 5 MR Residence 6 Other (Specify)

1 ☐ Yes 2 📆 No 27. Manner of Death 1 🔀 Natural 5 Pending investigation

Hospital: 1 | Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of

28c. Injury at Work? 28d. Describe how injury occurred 1 Tes 2 No

24a. Was an

perform 1□ Yes

2 X No

2 Accident 3 Suicide 4 Homicide

6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of

RES 000

29d. Date signed (Month, Day, Year)

T. Phillips, M.D., 31. Date filed (Month, Day, Year)

JUL 0 6

32 Registrar's Signature

1650 Orleans Street, Baltimore, Maryland

State Registrar

		Please	e Type or Prin						-		gible.		
		for State Registrar	State of Ma	aryland		rtment of Hi tificate of D		and M		giene Reg. No	007	21698	
Physicia	an	Decedent's Name (First, Middle, III)	Last)						2. Date of De		Year	3. Time of Death	
/Medic	al	As Facility Name (If not inetity tion	Brenda	C.	D&	nnenfels 4b. City, Town, or		of Dogth	06	30	3007 inty of Death	9:35 PM	
Examin		4a. Facility Name (If not institution, g		tal		Rosed	de	Dealli		BA	rLtin		
Funeral					ast birthday)	If Under 1 Year Months Days	If Under	Min.	8. Date of Birt (Month, Da	y, Year)	9. Birth	nplace (State or Foreign intry)	
Director		220-68-0821 Usual Residence of Decedent	-X-	50	Yrs.				Sept.	26,195	6 Mar	ryland	
how		10a. State 10b. County		10c. City	, Town or Loc	ation						10d. Inside City Limits	
28a-f s	Director	Maryland Ba	ltimore				undal	lk		40- Citiese	-418/h-4 C-1	1 □ Yes 2X No	
3a or 3		9 Patapsco Aven	າາຄ			10f. Zip Code	212	222			Citizen of What Country? United States		
ems 2	Funeral	11. Marital Status	12. Was Decedent 8 Armed Forces?	Ever in U.S	6. 13. W	 /as Decedent of His Yes, specity Cubar	spanic Ori	gin? (Spe	cify Yes or No	- 14.	Race - Ameri Black, White	ican Indian,	
", or it	by Ft	1 ☐ Never Married 2 ☐ Married 31 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ X If Yes, Give Year or Dates:	Vo	1	□Yes 2/ENo	Specify:	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,,		ecify:	_	
atural cat Ex		15. Decedent's	Education			ent's Usual Occupa				16b. Kind o	of Business/Ir	White ndustry	
Je. Med	Completed	(Specify only highest selementary/Secondary (0-12)	College (1-4or 5	i+)	life. D	aind of work done d O NOT use retired)	iuring mosi )	t ot workir	ng (				
Hygiel ther th		7 Years 17. Father's Name (First, Middle, La	nst)		Barn		18. Mothe	er's Name	(First, Middle,		vern		
Aental rked o	To Be	Wesley Coleman							Lee Bu		,		
and A is ma		19a. Informant's Name/Relationship			1	Address (Street a				-			
Health em 27 other to		Bobbiejo Fauver  20a. Method of Disposition	(Daughter)	20b. PI	ace of Dispos	inor Lan			re, Ma:		2121 on - City or T		
points. I agost lanks about to meet miller to the points are regard must be way as Important of Health and Mental Hygiene. Importants if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medikal Examiner must be notified at once.	•	1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe			-	atory or other place Service C		7/6/	2007		•	aryland	
epartir epartir nporta nce.		21. ign ure of Funeral Service Ltd	Censee /	0		Name and Addres				Dunda	lk, Ir	nc.	
10 E # 9		23a. Part1. Enter the disease, or co	·		79	22 Wise	Ave.	Dun	dalk,	Maryla			
hysician	8 8	shock, or heart failure. List or Immediate Cause (Final	only one cause on each lin	ne.	. Do not ente	L D	g, such as		. 1		cul	Interval Between Onset and Death	
/Medical		disease or condition resulting in death)	a. Due to (or as	a consequ	ence of):	1 4621	1111	101	/dis	س	JYN		
xaminer	_	Sequentially list conditions, if any, leading to immediate	Small	Ce	II CA	RCMor	na	OF	the le	ma			
ansit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events											
ian and urial-transit	= $ $												
physic the bi	dica	d											
anding use as	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome							23d. Date of delivery			
y the atte	Physician/Medica	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 □Live birth 4 □ Pregnant at 9 □ Unknown			Ectopic pregnancy Other (specify)					Month	Day Year	
within 54 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the burn	ğ	Part II. Other significant condition	s contributing to death b	ut not resu	lting in the un	derlying cause give	en in Part I.		23e. Did t			the cause of death?	
as bee	Completed								24a. Was		4b. Were aut	topsy findings available completion of cause of	
icate h									Yes perfo	ormed? 2 ☐ No	death?	2 🗆 No	
s certi	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital: Inpatie	ent 2 🗀 E	ER/Outpatient	3□ DOA Othe	or.		Check onl one 5 ☐ Resi		Other (Spec	rifu)	
th. : After thi s funeral	tion: T	27. Manner of Death  12 Natural 5 Pending 2 Accident investigat	28a. Date of Inju (Month, Da	ry	28b. Time of Injury	28c. Injury Work		2	28d. Describe				
after dea I Director d in by the	ertification:	3 Suicide 6 Could no determine				eet, factory, office		2	8f. Location ( City or To		umber or Rui	ral Route Number,	
e Funera	edical C	29a. Certifier (Check only one)  Certifying  Certifying	Physician: To the best xaminer: On the basis o and manner sta	f examinat	vledge, death ion and/or inv	occurred at the timestigation, in my op	ne, date ar pinion, dea	nd place, a	and due to the ed at the time,	cause(s) and	d manner as ace, and due	stated. to the cause(s)	
within To the comp	Me	29b. Signature and title of certifier	V/ (Olm	22	MD	29c. License	number	$\dot{\Box}$		29d. Date si	gned (Month	Day, Year)	
n		30. Name and address of person wi	ho completed cause of d	eath (Item	23a) (Type, F	Print)				01-	04.	-0001	
		DR TAISha Wi 31. Date filed (Month, Day, Year)	llioms 90	CO F	rankli	n Squar	e Di	2 P	altin	note 1	maryl	and 21237	
Sta Registr			2007 32 Registr	ars signat	de Los	de					*		

Harry Epps

JNK UNK	Stat	e of Maryland / Depa	artment of Health a			0.00	7 01/0
	1- For State Registrar		rtificate of Death		Reg.	No. ZUU	1 2109
/Physician Medical Examine	HARRY		EPPS	=1	2. Date of Death Month Day July 1, 2007	ay Year	3. Time of Death 0610 hrs
	4a. Facility Name (if not institution, § 5100 Baltimore National		4b. City, Town, o Baltimore	or Location of Death City		4c. County of Death	V/A
Funeral	Social Security Number     6.	Sex 7. Age (In yrs. I			. 8. Date of Birth (		thplace (State or
Director	212-53-10461	XM 2 F	32 Yrs. Months Da	ays Hours Min.	MARCH 2	2.1975 Foreig	untry) MARVLAUD
	Usual Residence of Decedent	Loo Oik	, Town or Location	****		7. i	10d. Inside City Limits
nd show any nce.	10a. State 10b. County	U/A	BALT	HORF	CITY		1 XYes 2 No
r death with the Maryland or items 23a or 28a-f show must be notitized at once. Funeral Director	10e. Street and Number		10f. Zip Code		- <b>J</b> 0g.	Citizen of What Cour	ntry?
h the ] 3a or lotifie	1118 50 M	ERSET STR	REET	2120	2:	USA.	
tems?	11. Marital Status  1 Never Married 2 Marri	12. Was Decedent Ever in U Armed Forces?		łispanic Origin? ( Sp an, Mexican, Puerto		14. Race - Ameri White, etc.	ican Indian, Black,
ter de: ", or i er mu		1 Yes 2 No	1 Yes 2 X N	lo specify:		Specify: B	LACK
ours aft	45 Barrier Education (Caralle	or Dates:	16a. Decedent's Usual Occup	pation (Give kind of w		3b. Kind of Business/	
6 72 hc an "ns cal Es	Elementary/Secondary (0-12)	Callege (1-4 or 5+)	during most of working lis	_			
5-0036  led within 72 hour Hygiene. tother than "natu the Medical Exan Completed	17. Father's Name (First, Middle, La	-4\	FORKLIA	TOPE	RATOR	WAREH	045E
215- be filed ntal Hyg nrked off ent, the		F FOO	K TO	SHELL		den Sumanie)	CIGHT
Ne man of		(Type, Print )	19b. Mailing Address (Stre			r, City or Town, State	, Zip Code)
e, MD I and 2 sho Health and item 27 is	OCTAVIA A. BRO	WN (SISTER)					1.21223
ore, s l an af Heal III iten	20a. Method of Disposition  1 Burial 2 Cremation		Place of Disposition (Name of c	cemetery,		Oc. Location - City or <b>Balto.</b>	Town, State
드라인동병	4 Donation 5 Other Spec	ity:	ODLAWN CEME	TERY 07-	05-07	WOODLAW.	N. MARULAND
Baltimore, M permit. Pages I and 2 Department of Health Important: If item 2 injury or other traun	21. Sunture of Funeral Service Lic	en ee	22. Name and Addre	ess of Faullity BA	ROWNJA	?. FUNER	44 HOME
Physician	23a. Part I. Enter the disease, or co	mplications that caused the death	. Do not enter the mode of dying	g, such as cardiac or	Trespiratory arrest,	shock, or heart	Approximate Interval
/Medical	failure. List only one cause on	each line. a, Multiple Injuries					Between Onset and Death
Examiner	or condition resulting in death)	Due to (or as a consequence o	of):				
-	Sequentially list conditions, if any, leading to immediate	b Due to (or as a consequence o	·f\·				<u> </u>
a in	cause Enter Underlying Cause (Disease or injury that initiated	c					4
ted Insit		Due to (or as a consequence o	f):				
be executed ician and inial - transit	UNPENDED	X AMENDED 20b,c I	<b>er</b> fh g869 7-0	6-07 <b>v</b> t		<del></del>	
). Box 68760, the death certificate be by the attending physic sched for use as the bur Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of preg		\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		23d. Date of delivery	
cian	past 12 months?	1 Live birth 4 Pregnant at time of de	2 Fetal death 3 eath 5 Other (Specify)	Ectopic pregna	incy	Month [	Day Year
Bo, e death the att	1 Yes 2 No 9 Unkno	wn 9 Unknown	Silver (Fig. 1)				
Vital Records, P.O. Be sician: The law requires that the de his certificate has been signed by the director, page 2 should be detached to Be Completed by Phy		s contributing to death but not r	esulting in the underlying cause	e given in Part I.	I	cco use contribute to 2 V No 3 Prot	the cause of death? pably 4 Unknown
Records,   The law requires ficate has been signage 2 should be Completed					24a, Was an autopsy		topsy findings available
eco he law te has					performe		_
tal Rectian: The certificate ector, page	25. Was case referred to medical		26.Pla	ce of Death (Check o			
f Vita Physicia or this ce ral direc	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient 3 DOA	Other Nursin	g Home 5 Re	sidence 6 🗸 Other	r: Scene
Affe		28a. Date of Injury (Month Day, Yaar) Jul 1, 2007	0000 1	jury at Work? Yes 2 ✔ No	28d. Describe how Driver auto tru		
vision Attender the de binecto in by the fical	2 Accident Investig 3 Suicide 6 Could n	28e Place of Injury - At hi	ome, farm, street, factory, office	building, etc.			ıral Route Number, City
Div pital o ours at ceral D filled i	4 Homicide determin		d / Highway		or Town, State 5100 Baltimore N	National Pike Rout	e 40 , Baltimore City,
Divisior  To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the I		ician: To the best of my knowled ner:On the basis of examination a	-				
To To COIT	29b. Signature and title of certifier/	and manner stated	29c. Licer	nse number	29	9d. Date signed (Mo.	nth, Day, Year)
	AICW	MIN	0.0	C.M.E.	J	luly 2, 2007	
6	30. Name and address of person wh				201		
. ]		sistant Medical Examiner		altimore, MD 21:	201		
State Registra		2007 32. Rystrar's Signatu	11 Process				

State of Maryland / Department of Health and Mental Hygiene

4 For

			Registrar			Cer	tificate d	of Deat	h		Reg. No.			
			1. Decedent's Name (First, Middle, Last)  2. Date of Death  Name (First, Middle, Last)  3. Time of Death											
	Physici		JAMES PAUL	FARDIS						JUly	04	2007	192	j M
	/Medic Examin		4a. Facility Name (If not institution	. give street and num	ber)		4b. City, Tow	n. or Location	n of Death	0 5119	4c. County of Death			
	Examin	er	GOOD SAMARITAN		,						N/A			
			5. Social Security Number		7. Age (In yrs. ia:	et hirthday)							lace (State or F	Foreign
	Funeral			1 <b>∑</b> M 2□F		Yrs.		ys Hours	Min.	(Month, Da	y, Year)	Coun	itry)	oreign
	Director		171-44-7716 Usual Residence of Decedent		55					9/12/	1951	NEW	JERSEY	
	and *		10a. State 10b. County		10c. City.	Town or Lo	cation					1	0d. Inside City	Limits
	sho	2											1 ☐ Yes 2	
	N 98 -1	ctc	MD BALT	LMORE	PI	ARKVIL								
	ith th	Director	10e. Street and Number				10f. Zip Co	de			10g. Citizen of	What Coun	ntry?	
	23a	a	1809 YAKONA RO	DAD			21	234			USA			
	ep sue	Funerai	11. Marital Status	12. Was Deced	dent Ever in U.S.	13. \	Was Decedent f Yes, specify	of Hispanic C	Origin? (Spec	ify Yes or No	- 14. Ra	ce - Americ		
9	be tiled within 72 hours after death with the Maryland ital Hygiene. bd other then "natural", or ttems 23a or 28e-f show event, the Medical Examerations in the Leavent.	Ē	1 Never Married 2 Marr				1 ☐ Yes 2 💢			iouri, oto.,				
21215-0036	rai.	l by	3 ☐ Widowed 4 🕅 Divorced	Year or Da	tes:		. □ 1.00 5 <b>7 7</b>	140 Зреси	у.		Speci	yy: WHJ	[TE	
9	72 hc	Completed	15. Decedent	t's Education		16a. Deced	tent's Usual O	cupation	ant of working		16b. Kind of E	Business/Inc	dustry	
7	hin .	pie	(Specify only highes Elementary/Secondary (0-12)	College (1-	4or 5+)	life. L	kind of work do DO NOT use re	atired)	OSI OF WORKING	9				
21	filed within Hygiene. other then "	Б	12TH GRADE	Conogo (1	10,077	OPTIC	CAL LAB	TECHN	ICAN		WALLI	MAN OF	PTICAL	
	Hyg othe	Bec	17. Father's Name (First, Middle,	Last)				18. Mot	ther's Name	(First, Middle	Maiden Suma	me)		
an	d be ental ced o	o B	JOHN FARDIS					JEA	N ELLE	N BURN	VETTE			
Maryland	2 should be and Mental is marked o	P_	19a. Informant's Name/Relations	hin (Tuna Print)		19b Mailin	a Address (St	root and Num	har ar Pural	Pouto Numb	er, City or Town	State 7in	Codol	
Z	12 s h an 7 is i	1					-			MORE,		, 314 234	0000	
	s 1 and 2 f Health item 27 other tr		PATRICIA KROM/	TAIVCE	OOL OI		YAKONA							
0	ges of the		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation	3 □Removal from S	0.00	netery, cren	sition (Name o natory or other	place)	Da	110	20c. Location	- City or To	own, State	
Ē	it. Pages 1 and 2 should afment of Health and Men rtent: If item 27 is marke njury or other treumatic		' 4 □ Donation 5 □ Other (S			RO CRE	EMATORY	. INC.	7/5/	2007	CATONS	VILLE,	MD	
Baltimore,			21. Signature of Funeral Service	Licensee //			. Name and A				SON FUNI			. A.
m	Department Impounts		Heale	N. H	911-	- 81	521 LOC	H RAVE			VSON, M			
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that ca	used the death.									
													Approximate Interval Betwe Onset and Dea	en ath
	Physician	8	Immediate Cause (Final disease or condition resulting in death)	-a. ALU	TE M	YOCA	2-DIA	ノエ	JFA2	CTIC	N			
	/Medical Examiner		rooding in dodiny	Due to (c	or as a conseque	nce of):						12	223	
	- Adrillion		Sequentially list conditions.	4THE	or as a conseque	-EFC	TIC !	ART	IOVAC	سالاعم	12 DIS	E46E_	(EXE	2
	p =	nei	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (d	or as a conseque	nce of):								
W	be executed sician and burial-transit	Examiner	that initiated events	c										
o,	exe an an rial-t		resulting in death) Last	Due to (d	or as a conseque	nce of):								
9/	te be ysici e bu	cal		d										
68760,	certificate be executed iding physician and ise as the burial-transit	edi												
ŏ	h certific anding p use as	n/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outo	ome of pregnant	су					23d. D	ate of delive	erv	
ğ	The law requires that the death ate has been signed by the atter bage 2 should be detached for u		in the past 12 months?		rth 2 ☐ Fetal d ant at time of dea	leath 3	Ectopic pregn Other (specifi	ancy				lonth	Day Yea	ar
o.	at the death by the atte	Physicia	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unkno			J Other (apoch)	//						
Δ.	that the the the the the the the the the th	Ph	Part II. Dther significant condition	one contributing to do	ath but not recult	ing in the u	adashina sawa	a course in Re-	e I	230 Did t	obacco use cor	atributa to th	an cause of dea	ath?
Ś	res ti igne be c	by	Tartii. Diner significant conduct	ma continuating to dec	atti but not result	ang in merun	nuerlying causi	given in Fai	ι.				\/	
ord	w require been si	Completed								الا	Yes 2□No	3 Prob	ably 4 Uni	known
S	aw ri s be 2 sh	pie								24a. Was		Were auto	psy findings av	allable
ä	The lavate has	E C									ormed?	death?	mpletion of cau	se or
a		C	25. Was case referred to medical					00 FI		1 □ Yes	2 No	1 🗆 Yes	2 No	
Vital Record	Physicien: this certific ral director,	o B	examiner?	Hospital	V	50.		Othor		(Check only o				
of	Phy: this aldi	-	1 ☐ Yes 2 ☐ No 27. Manger of D th	28a. Date o		R/Outpatien 8b. Time of		4 🗆			dence 6 🗆 Ot		y)	
ũ	ing After	lon	1 Natural 5 ☐ Pendin	g (Month	Day Year)	Injury		Injury at Work?		ou. Describe	now injury occu	rred		
Division	Attending ir death. ector: After by the fune	cat	Accident investig				М	1 Yes 2	No					
≅	r Att	ţ	/ 3 ☐ Suicide 6 ☐ Could in determine	ined 286 Place	of Injury - At horr g, etc. (Specify)	e, farm, str	eet, factory, of	ice	28	Bf. Location (	Street and Nurr wn, State)	ber or Rura	il Route Numbe	H,
0	To the Hospital or Attendi within 24 hours after death. To the Funeret Director: A completely filled in by the fi	Certification:							1					
	ospi hou uner ly fills		29a. Certifier 1 Certifyin	g Physician: To the	best of my know	edge, death	occurred at th	ne time, date	and place, ar	nd due to the	cause(s) and n	nanner as si	tated.	
	To the Hospital within 24 hours a To the Funerel I completely filled	edical	one) /2   Medicel	Examiner: On the ba and mann	sis of examination er stated.	n and/or in	vestigation, in i	ny opinion, d	eath occurre	a at the time,	date and place	, and due to	tne cause(s)	
	rott Mithii Tott	ĕ	29b. Signature and title of certifier				29c. Lie	ense nu <i>m</i> be	r		29d. Date sign	ed (Month,	Day, Year)	
			1	-/(	MD		1	5899	9		714	7-0	507	
	. 1.1		Yes	7			1	20 (	(		01 (1			
	10T1		30. Name and a dress of person		of death (Item 2									
	V			JOSEPH	7601 6		PAVEN	BU	D B	LLTIM	OPE, N	10 2	1238	
	Sta		31. Date filed (Month, Day, Year)	2007 32/8	gistrar's Signatu	2 A	want o							
	Registr	ar		100	State State State	1	C. Car							

			T- State of Maryland Registrar	-	rtment of F tificate of			giene Reg. No. 🤈 🔒 🕦	7 01701
	Physici		Decedent's Name (First, Middle, Last)     DOROTHY ELIZABETH FANCHER				2. Date of Dea Month July 4	Day Ye	3. Time of Death 3:45 p
	/Medic Examin Funeral Director		4a. Facility Name (If not institution, give street and number)  Cherry Lane Nursing Home  5. Social Security Number  418-22-5061  6. Sex  1 M 2 X F  84	st birthday) Yrs.	4b. City, Town, or  Laure1  If Under 1 Year  Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day 03-31-1	4c. County of E Prince h v. Year) 9.	
2	after death with the Maryland or items 23a or 28a-f show miner must be notified at	/ Funeral Director	Usual Residence of Decedent  10a. State 10b. County 10c. City,  Maryland Prince George's Lau  10e. Street and Number  9001 Cherry Lane  11. Marital Status  1 □ Never Married 2 □ Married   12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ☒ No   If Yes. Give		10f. Zip Code 20705	lispanic Origin? (Spe an, Mexican, Puerto Specifv:		10g. Citizen of Wha	10d. Inside City Limits  1 ☑Yes 2 ☐ No t Country?  American Indian, White, etc.
N 2 12 13-000	e filed within 72 hours ti Hygiene. other than "natural", rent, the Medical Exa	Be Completed by	3 X Widowed 4 □ Divorced Year or Dates:  15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	16a. Deced (Give I life. D	ent's Usual Occup	oation during most of worki d) ervisor		16b. Kind of Busin	White ess/Industry School System
alumore, maryian	permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	To Be	T Buriar 2 M Cremation 3 Hemovariron State	7408 ince of Disposimetery, cremopolit	Morrison sition (Name of natory or other place an Cremat Name and Addre	Drive, G  ce)  ory 07-0  ss of Facility	reenbel Date 6-2007	t, MD 207 20c. Location - City Alexandr 4739 B	70
<b>X</b>	ate be executed  /Medical Examiner  the burial-transit	dical Examiner	23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  A. Respiratory Due to (or as a conseque conseque)  b. General Debil Due to or as a conseque c	Do not enter Cailurence of): Lity	er the mode of dyir	uneral Ho			Approximate Interval Between Onset and Death
.0.	at the death certific by the attending p stached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown  23c. If yes, outcome pf pregnand 1 ☐ Live birth 2 ☐ Fetal d 4 ☐ Pregnant at time of dea	death 3□ ath 5□	Ectopic pregnancy Other (specify)			23d. Date o Month	Day Year
11000103	The law requires that the disate has been signed by the page 2 should be detached	Completed by F	Part II. Other significant conditions contributing to death but not result  Severe Constipation	ing in the un	derlying cause giv	en in Part I.	1 🗆 Y	an 24b. Wer prio dea	re autopsy findings available r to completion of cause of th?  Yes 2 \( \) No
	To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death, within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending i completely filled in by the funeral director, page 2 should be detached for use as	Certification: To Be		28b. Time of Injury		y at k? Yes 2 □ No	me 5 ☐ Resid 28d. Describe h	dence 6 Other (now injury occurred	(Specify) or Rural Route Number,
	To the Hospita within 24 hours To the Funera completely fille	Medical C	29a. Certifler (Check only one)  1  Certifying Physician: To the best of my knowl 2  Medical Examiner: On the basis of examination and manner stated.	edge, death on and/or inv	29c. Licens	opinion, death occur e number	red at the time,	cause(s) and mannidate and place, and 29d. Date signed (A	I due to the cause(s)  Month, Day, Year)
OH	Sta Registr WH 17 Rev 1/2	ar	30. Name and address of person who completed cause of death (Item 2 Adebowale Isaac Ajayi, MD 620 31. Date filed (Month, Day, Year) 32. Registrar's Signature JUL 0 6 2007	Ol Gre	enbelt R	oad, Suit	e U15,	College P	ark, MD 20740
				ORK	GINAL				

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Marylan	d / Depart			•		07	217	02
	Physici	an	Decedent's Name (First, Middle, Last)	ROY STANI	TY FID	DESOP		2. Date of De Month	Day	Year	3. Time o	f Death
1	/Medio	cal	4a. Facility Name (If not institution, give				or Location of Death	7-		unty of Death	4	J- M
	Examir	ier	CARROLL HOSPIT			•	MINSTER			RROLL		
	Funeral		Social Security Number     6. Sex	7. Age (In yrs.		f Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Bi (Month, D		9. Birth	place (State	or Foreign
3	Director		220-42-3910	M 2□F 6	3 Yrs.	MOTHETS Days	Flours Will.	1/17/	71944		<sup>intry/</sup> DIS' DLUMB:	
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Locat	ion					10d. Inside C	
	Maryl feho jed a	ō	MD CARROI		TANEYT						1 XYes	2 No
	r 28a	Director	10e. Street and Number			10f. Zip Code	·-···········		10g. Citizer	of What Cou	ntry?	
	th with		19 BANCROFT ST			217	787		US	A		
	r dea	Funerai		12. Was Decedent Ever in U. Amed Forces?	.S. 13. Wa	s Decedent of I	Hispanic Origin? (Span, Mexican, Puerto	ecify Yes or No Rican, etc.)	0- 14.	Race - Ameri Black, White		
36	s afte	by Fi	1 ☐ Never Married 2∑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates:		Yes 2₹ No				ecify: WH	TTE	
21215-0036	72 hours after death with the Maryland naturel', or items 23a or 28a-f ehow disal Examinar must be rodified at		15. Decedent's Edu	cation	16a. Deceden	t's Usual Occup	pation			Kind of Business/Industry		
215	⊆ ₫	piet	(Specify only highest grad	completed) College (1-4or 5+)	(Give kin	d of work done NOT use retire	during most of work	ang			,	
21	filed with Hygiene. other ther	Completed	12	4	S	TEAM I				TRUCT:	ION	
Maryland	should be fill and Mental Hy marked oth	To Be	17. Father's Name (First, Middle, Last) ALE	C FIDD	ESOP		18. Mother's Name (First, Middle, Maiden Surname) FRANCES UNTAKEN					
Man	2 shaand and 18 m		19a. Informant's Name/Relationship (Ty		_		and Number or Ru				0 Code) 1787	
	s 1 and 3 Health Item 27 othsr tr		DENISE A. FIDDE		I 9 BA		r st., T	Date		ion - City or T		
סר	Dr of		1 ☐ Burial 2 ☑ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	emetery, cremat	ory or other pla			7 WTN	IETET.D	MD	
Baltimore,	Department mportant: eny injury		4 □ Donation 5 □ Other (Specify)  21. Si naura o Futeral Struce Licens	2001	n CARR	lame and Addre	ess of Facility FL	77370 RTCHED	FINE	T T T T T	OME	PΔ
Ba	Depril		1000				IN ST.,					
- 大	Physician /Medical Examiner	iner	23a. Part 1. Enixf the disease, or compleshock, or seaft failure. List only or immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a.  Due to (or as a conseq  Due to (or as a conseq	uence of):	VCEPI	ng, such as cardiac HALOPA JEUMO	or respiratory and THY	arrest,		Approxima Interval Be Onset and	tween
.O. Box 68760, %	The law requires that the death certificate be executed ate has been signed by the ettending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical Examiner	IF FEMALE	Due to (or as a conseq d.  3c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown	ancy Ideath 3⊟Ec	etopic pregnanc ther (specify) _	у		230	Date of delive	•	Year
0	that the		Part II. Other significant conditions con	ntributing to death but not res	ulting in the unde	riving cause giv	ven in Part I.	23e. Did	tobacco use	contribute to	the cause of	death?
Records,	uires sign d be	d by	END-STAGE	RENAL I	DISEAS	₹E		10	Yes 2X	lo 3□Pro	bably 4 🗆	Unknown
CO	w requir	Completed	CORONARY A	PRTERY D	1SEAS	E		24a. Was	s an 2	4b. Were aut	oosv findings	available
	The lav	Ë							opsy ormed?	prior to co death?	ompletion of o	cause of
Vital		0	25. Was case referred to medical	77-72			26. Place of Dea	1 ☐ Yes	One No	1 1 105	2[] NO	
of <	S	ToB	examiner? 1 ☐ Yes 2 No	lospital: Inpatient 2	ER/Outpatient	3□ DOA Ott	her: 4 Nursing H	ome 5 Res	idence 6	Other (Speci	fy)	
0 4			27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju	ry at rk?	28d. Describe	how injury o	ccurred		
Sio	at at	cati	2 Accident investigation 3 Suicide 6 Could not be				]Yes 2□No		70.			
Division	tal or Attendi s after death. al Dirsctor: A ed in by the fu	Certification:	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, street y)	, factory, office		28f. Location City or To	(Street and N own, State)	lumber or Rur	al Route Num	nber,
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	edicai C	29a. Certifier (Check only one) Certifying Physical Exami	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, death or tion and/or inves	ccurred at the ti	me, date and place opinion, death occur	and due to the	cause(s) an , date and pla	d manner as	stated. to the cause(:	s)
	To the Mithin Fo the	Me	29b. Signature and title of certifier	11		29c. Licens			29d. Date s	igned (Month	Day, Year)	
			1 Dan			D	30263	63 7-2-07				
	9		30. Name and address of person who co		n 23a) (Type, Pri	nt)	E, WEST					
*	Sta Registi		31. Date filed (Month, Day, Year)	32. Registrar's Signa	H. Lo	este)						

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 2. Date of Death Year

1 - State Registrar 1. Decedent's Name (First, Middle, Last) July 2, 2007 **Physician** Virginia R. Fearson /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Montgomery Hospice Casey House Rockville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan. 29, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 ☐ M 2 📆 F 80 Director 577-36-1339 Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland ealth and Mental Hygiene. 10c. City, Town or Location 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at Director Silver Spring Montgomery Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20903 10110 New Hampshire Ave., Apt.#204 Funeral 14 Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 "natural", or Specify: þ 3 Widowed 4 □ Divorced al Hygiene. I other than "natura event, the Medical E Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Pharmacy Drug Clerk 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be is marked Nettie Campbell Raymond Whipp 9 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any injury or other trau 1310 Hornell Dr., Silver Spring, Maryland 20905 Michael Fearson / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 ament of He 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Silver Spring, Maryland July 7, 2007 Gate of Heaven Cemetery 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licer 22 Name and Address of Facility, Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 W. Montgomery Ave., Rockville, MD 20850-2805 M00896 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Immediate Cause (Final a End Stage Chronic Obstructive Pulmonary Disease **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine and burial-trai resulting in death) Last Due to (or as a consequence of) Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy for 4☐Pregnant at time of death
9☐Unknown in the past 12 months? 5 ☐ Other (specify) 2 🔯 No detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Urosepsis Completed Lung mass with pleural effusion 24a. Was an

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760 page 2 should be detact certificate director After Hospital or Attending after death.

I Director: A
d in by the fu

23e. Did tobao	co use con	tribute to the cau	se of death?
1 ☐ Yes	2□ No	3⊠ Probably	4 □Unknow

Month

Day

Year

3. Time of Death

11:30 P.M

9. Birthplace (State or Foreign

10d. Inside City Limits

Approximate Interval Between Onset and Death

1 ☐ Yes 2 ☑ No

Washington, D.C.

White

Black, White, etc.

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? 1∐ Yes 2 X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 MOther (Specify) Hospice 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide

		1		 - 1	
29a. Certifier (Check only one)			sis of examina	rred at the time, date and place, and due ation, in my opinion, death occurred at the	to the cause(s) and manner as stated. time, date and place, and due to the cause(s)
29b. Signature and	title of certifier	1 6	/	29c. License number	29d. Date signed (Month, Day, Year)

10064615

Grenene Wrolles & mi) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Genevieve Anne Wroblewski, M.D., 6001 Muncaster Mill Rd., Rockville, MD 20855

State Registrar

Be

Certification: To

Medical

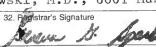
filled in t

within 24 hours al

To the Funeral C

completely filled i

31. Date filed (Month, Day, Year) JUI



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 522 Ferguson am 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Deatl Examiner Pal tim ore st birthday) If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs 9. Birthplace (State or Foreign **Funeral** 48-2588 Carolina Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. Director 1 Tores 2 □ No larxlar 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Yes 2 **€** If Yes, Give Year or Dates: 1 Never Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Completed by 3 Widowed 4 Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) Be erauson ပ္ 19a. Informant's Name/Relation nip (Type. Print) 19b. Mailing Address (Street and Number or 4106 Edward 20b. Place of Disposition (Name of cemetery, crematory or other 20a. Method of Disposition 1 Deurial 2 □ Cremation 3 Removal from State 1 mints 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lio 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. I val Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner wides Dreak Ces Com Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine DIVISION Or Vital Records, P.O. Box 68760, & To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) □Yes 2□No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🔲 Yes 2 □ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy this certificate 2 No 1∐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 21 No Hospital: Other: 1 Inpatient 2 2 ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? After 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director; completely filled in by the f 2 Accident 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certification 29d. Date signed (Month, Day, Year) MD 30. Name and address of person who completed cause of death (Item-23a) (Type, Print) R 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 0 6 200 Registrar

ORIGINAL

DHMH 17 Rev 1/2001

			For State	State of Maryl		artment of Health and rtificate of Death		4001	21705	
			Registrar  1. Decedent's Name (First, Middle, La.	st)	001	tineate or Beatin	2. Date of Death		3. Time of Death	
	Physici /Medio		Myrle	Wood	Flana		July	1, 200 7 ar	8:09A. M	
j	Examir	er	4a. Facility Name (If not institution, given Harford Memoria		L	4b. City, Town, or Location of D Havre de Gra		4c. County of Deat Harford	th	
	Funeral Director		2 12 30 1720		yrs. last birthday) 76 Yrs.	If Under 1 Year II Under 24 I Months Days Hours N	Min. B. Date of Birth Dec 9,	9. Birth	hplace (State or Foreign ourin) Carolin	
	land ow		Usual Residence of Decedent  10a. State 10b. County	10c	. City, Town or Lo	cation			10d. Inside City Limits	
	e-fsh	ctor	Md. Harfor	: d	Abingd	on			1 □ Yes 2 □ No	
	ath with th	Funeral Director	10e. Street and Number 100 Waldon Roa	ad Apt. E.		10f. Zip Code 21009		10g. Citizen of What Country? U.S.A.		
980	72 hours after death with the Maryland nature!, or Iteme 23a or 28e-f show Acal Examiline Invest be inclified at	Ď	11. Marital Status  1 Never Married 2 Married  3 Wildowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give A Year or Dates:		Was Decedent of Hispanic Origin? f Yes, specify Cuban, Mexican, Pi	? (Specify Yes or No- uerto Rican, etc.)	14. Race - Ame Black, White Specify: W	nican Indian, e, etc. hite	
21215-0036	S . c .	Completed	15. Decedent's E. (Specify only highest grade) Elementary/Secondary (0-12)	ducation de completed) College (1-4or 5+)	(Give	dent's Usual Occupation kind of work done during most of DO NOT use retired)  ity Control I	16b. Kind of Business/	ŕ		
Maryland 2	2 should be filed with and Mental Hygiene ie marked other the sumatic event, Ital	To Be C	17. Father's Name (First, Middle, Last, Wilber Barnhil				Name (First, Middle, N			
Many	2 should and Men le marke raumatic	İ	19a. Informant's Name/Relationship (			ng Address (Street and Number of				
	s 1 and 2 should of Health and Mer treum 27 le marke other traumatic		Danny Wood (so		b. Place of Dispo	Winterberry D		ewood, Mo 20c. Location - City or		
Baltimore,	t. Pege rtment c rtent: If njury or		1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification 5 ☐ Other (Specification of Funeral Service Licents)	y) E	Bayview	natory or other place)  Crematory 7 -	- Links		,Maryland	
Ba	Depermine Depermine Control on Irange Control on		Polut Pod	Jack D	12	<sup>t. Name and Address of Facility</sup> K 201 Dunda1k A	ve. Balt:	imore, Mo	1. 21222	
	Physician /Medical		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	aPn	eumoi		diac or respiratory arre	st,	Approximate Interval Between Onset and Death	
1	Examiner			Due to (or as a con	isequence ol):					
6	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Dise to (or sis a non	saquenca of):					
68760,	ficate be executed physicien and is the burial-transit	edical Exa	resulting in death) Last	Due to (or as a con	sequence of):					
		Medi	IF FEMALE:							
P.O. Box	The law requires that the death certifi tte has been signed by the attending bage 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2X No 9 ☐ Unknown	23c. If yes, outcome of pre 1 Live birth 2 I 4 Pregnant at time 9 Unknown	Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of deli Month	ivery Day Year	
	w requires that been signed b should be dete	þ	Part II. Other significant conditions of	ontributing to death but not				s 2 No 3 Pro	othe cause of death?	
Division of Vital Records,		Completed	·				24a. Was an autopsy perform	prior to death?	utopsy lindings available completion of cause of	
Vita	Physiclen: r this certific ral director, r	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital:	2 ED/0 +		Death Check only one	il.		
J of	ng Phys ter this neral di		27. Manner of Death	28a. Date of Injury (Month, Day Yea	2 ER/Outpatien 28b. Time of Injury	1 3 DOA 4 INUISIN	g Home 5 ☐ Resider		cify)	
visio	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: Atter completely filled in by the funer	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	1	At home, larm, stre	M 1 Yes 2 No	281 Location (Str City or Town,	reet and Number or Ru	ural Route Number,	
ā	oltel or urs afte erel Dire			A contract of						
	ne Hospitel on 24 hours a ne Funerel Dietely filled i	edical	29a. Certifier Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my niner: On the basis of exan and manner stated.	knowledge, death nination and/or inv	n occurred at the time, date and pl vestigation, in my opinion, death o	lace, and due to the ca occurred at the time, da	use(s) and manner as ite and place, and due	stated. to the cause(s)	
	To the within 2 To the complet	W	29b. Signature and title of certifier	وسر		29c. License number D 3 5 0	12 3	Od. Date signed (Month	h, Day, Year) 2067	
	4		30. Name and address of person who	completed cause of death (	(Item 23a) (Type,					
	Sta Registr		31. Date filed (Month, Day, Year)  JUL 0 6 20	Registrar's S	ignature	Print) North Ave				

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 11:02 M 200 Rodney Raymond Folsom 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Washington Washington County Hospital Hagerstown If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Davs | Hours | Min. | (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 528-66-1835 60 Feb 9, Connecticut Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2√ No Washington Hagerstown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21740 138 E. North Avenue USA 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: white 3 Widowed 4 Divorced 166-72 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15 Decedent's Education

filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at Baltimore, Maryland 21215-0036

For State Registrar

10a. State

MD

Director

Funeral

þ

Be Completed

2

Examiner

Physician/Medical

Be Completed by

Medical Certification: To

**Physician** 

/Medical

Examiner

**Funeral** 

Director

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlat-transit

Division or Vital Records, P.O. Box 68760,

(Specify only highest gr	ade completed)	(Give kind of work done life. DO NOT use retired	during most of working			
Elementary/Secondary (0-12)	College (1-4or 5+)	technicia	•	aerospace		
17. Father's Name (First, Middle, Las	t)		18. Mother's Name (First, Mi	ddle, Maiden Surname)		
Rodney Terry Fol	Lsom		Beatrice Ju	ne Smith		
19a. Informant's Name/Relationship Dorothy Folsom/s			and Number or Rural Route N Avenue Hagers	umber, City or Town, State, Zip Code) town, MD 21740		
20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐  4 ☒ Donation 5 ☐ Other Species	□Removal from State	Place of Disposition (Name of cemetery, crematory or other place	ce) Date	20c. Location - City or Town, State		
1/2/22 21	Wade Directo	Roltimore	MD 21201	W. Baltimore Street		
Immediate Cause (Final disease or condition resulting in death)	notications in a caused the deat yone cause in each line.  The state of the caused the deat yone cause in a cach line.  Due to (or as a lons)	th. Do not enter the mode of dyin	ng, such as cardiac or respirat	ory arrest,  Approximate Interval Between Oyset and Death  Authority Communication of the Com		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last	Due to (or as a conseq d.	<del>/                                    </del>	leseons	75 Jeans		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregnation 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of continuous forms of the continuous forms o	al death 3 Ectopic pregnanc	у	23d. Date of delivery Month Day Year		
Part II. Other significant conditions	contributing to death but not res	//	ren in Part I. 23e.	Did tobacco use contribute to the cause of death?  1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown		
Chlesthimo	Myselyn m affel Co	delles:		Was an autopsy findings available prior to completion of cause of death?  /es 2 ☐ No 1 ☐ Yes 2 ☐ No		
25. Was case referred to mexaminer?			26. Place of Death (Check of	only one)		
1  Yes 2 10	Hospital: 1 4 Impatient 2	]ER/Outpatient 3 DOA Oth	ner: 4 Nursing Home 5	Residence 6 Other (Specify)		
27. Manner eath 1	28a. Date of Injury (Month, Day Year)	28b. Time of Injury World M 1	ry at rk?  Yes 2 □ No	ribe how injury occurred		
3 ☐ Suicide 6 ☐ Could not I determined		ome, farm, street, factory, office fy)	28f. Locat City o	ion (Street and Number or Rural Route Number, or Town, State)		
29a. Certifier 1 CertifyIng P (Check only one) 2 Medical Exe	hysician: To the best of my kno aminer: On the basis of examina and manner stated.	owledge, death occurred at the ti ation and/or investigation, in my o	me, date and place, and due t opinion, death occurred at the	o the cause(s) and manner as stated. time, date and place, and due to the cause(s)		
29b. Signature and title of certifier	how MD	29c. Licens	se number	29d. Date signed (Month, Day, Year)  TUG 2 2007		

DHMH 17 Rev 1/2001

State

Registrar

200 HAGUSTON MD 21140

30. Name and address of person who completed cause of death (Item 23a) (Type 324 East ANTICHM STAUT)

31. Date filed (Month, Day, Year)

0 6

32. Registrar's Signature

		•	For State Registrar	State of Ma	aryland			t of Hea			giene Reg. No.	007	21707
المحاف		_	1. Decedent's Name (First, Middle, Last)							2. Date of Dea		Vane	3. Time of Death
Phys	sicia edica		Marie H. Gast							July 3,	Day 200	Year 7	7:40 P M
Exam		1	4a. Facility Name (If not institution, give s	treet and number)			4b. City,	Town, or Loca	ation of Death			county of Deat	h
			111 A Sunshine Ct				For	est Hi	11		Ha	rford	
Funer	ral		5. Social Security Number 6. Sex			ast birthday)	If Under		Jnder 24 Hrs. ours Min.	8. Date of Birt	h	9. Birt	hplace (State or Foreign
Direct	or		218-22-59/0	M 2 <b>X</b> □F	80	Yrs.		55,5		04-12-1	927	Miss	sissippi
p v		-	Usuel Residence of Decedent  10a, State 10b, County		10c City	, Town or Lo	cation						10d. fnside City Limits
laryla •ho		_											1 □ Yes 2X□ No
he N		0	Maryland Harford  10e. Street and Number		FO	rest l	1111 10f. Zig	Codo			10a Citiza	en of What Co	
with a			111 A Sunshine Ct										contry :
eeth		Funeral		2. Was Decedent	Ever in II 9	S 13 V	210		ic Origin? (S	pecify Yes or No	U.S.2	A . 4. Race - Ame	nican Indian
ter d		Š	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 1 1		10.1	f Yes, spe	cify Cuban, M	exican, Puert	o Rican, etc.)		Black, White	
J.S. aris at all and a second		by	3 X Widowed 4 □ Divorced	ff Yes, Give Year or Dates:			I ☐ Yes	2X No Sp	pecity:		5	Specify:Whi	te
C 21215-U036 filed within 72 hours atter deeth with the Maryland Hygiene. Wher then "naturel", or Iteme 23a or 28a-1 ehow ent, the Medical Examinar must be notified at		ted	15. Decedent's Educ			16a. Deced	lent's Usu	al Occupation		4.:	16b. Kind	d of Business/	Industry
CT2		Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5	(+)	life.	NOT u	ork done during se retired)	g most of wor	King			
d with		Š [	10			Housev	rife				0wn	Home	
oth Hy		Be	17. Father's Name (First, Middle, Last)					18.	Mother's Nar	ne (First, Middle,	Maiden S	lumame)	
Maryland 21215-UU36 d 2 should be filed within 72 hours at th and Mantal Hyglene. Ty Is marked other then "naturel", or treumatic event, the Medicial Exam		၉	Michael Frank						Franci	s Rug			
Tary 2 sho and 1 1s mu	- (3		19a. Informant's Name/Relationship (Typ	oe, Print)		19b. Mailir	g Address	s (Street and f	Vumber or Ru	ıral Route Numbe	er, City or	Town, State, 2	Zip Code)
and and		-	Joseph M. Gast (Son	1)					Ct For	est Hill			
IOFE, Maryland 21215-UU36 ges 1 and 2 should be filed within 72 hours atter deeth with the Marylan at of Health and Mental Hygiene. It file az 71 is marked other then "naturel; or Iteme 23e or 28e-1 ehow or other freumatic event, the Madical Examinational be notified as			20a. Method of Disposition  1 X Burial 2 □ Cremation 3 □ Re	emoval from State	20b. Pl	lace of Dispo emetery, cren	sition (Na. natory or d	me of other place)		Date	20c. Loc	ation - City or	Town, State
Pag Pag Int: I			4 Donation 5 Other (Specify)	sinovai noin state	Ho1	1y HII				6-2007	Midd	le Rive	er, Maryland
Baltimore, permit. Pages 1 ar Depertment of Hea importent: if Item 3	once	- [	21. Signature of Funeral Service License	,/		22	. Name a	nd Address of	Facility Sc	himunek	Fune	ral Hom	ne of Bel Air
0 83E\$	ä		Maria	//		Ir	ıc. 6	10 W. 1	MacPha	il_Rd_Be	1 Ai	r, MD 2	21014
		Inc. 610 W. MacPhail Rd Bel Air, MD 2  23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											
Pnysicia	an		fmmediate Cause (Final disease or condition	retast	e le	eny	Canco	~		Onset and Death			
/Medic	_		resulting in death)	Due to (or as		-			0				
Examin	-		Sequentially list conditions, b										
4 D =		Examiner	ri any, leading to immediate cause. Enter Underlying Cause (Disease or injury	derice of).									
transit		am	Cause (Disease or injury that initiated events resulting in death) Last										
SO, se exe		Ě	lesuling in dealify cast	Due to (or as	a consequ	Jence of):							
I Records, P.O. Box 68760, C. The law requires that the death certificate be executed at the see been signed by the attending physicien and asge 2 should be detached for use as the burist-transit		dicai	d										
Box 6 leath certific attending p		0 .	IF FEMALE:	To Hugo outcome	of process								
BOX eath cert attendin for use		Physician/M	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome 1☐Live birth	2 Fetal	ldeath 3□	Ectopic p				23	3d. Date of dei Month	livery Day Year
the de		/sic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4⊡Pregnant at 9⊡Unknown	time of de	eath 5L	Other (s)	оөсify)					
that the de led by the a detached t		P.	Part II. Other significant conditions con	tributing to death h	ut not resi	ulting in the u	nderlyinn (	cause given in	Part I	23e, Did t	obacco us	e contribute to	the cause of death?
Records, F he law requires tha e has been signed age 2 should be de	1	6	Tarris of the argument of the	induing to doubt b		-		sauto givoir ii		10	/		robably 4 Dunknown
COrd: w require been signal		Completed								4	-		
Hec		ğ								24a. Was		24b. Were at prior to death?	utopsy findings available completion of cause of
Thr										1 Yes	2 No		2 □ No
VITAL SICION: 1 CONTINENT FICTOR FICT		Be	25. Was case referred to medical examiner?	ospital:				26. Other: 4	Place of Dea	ath Check only	оле)		
Phys this al dir		၉	1 165 2 310	1 🗀 inpatie		ER/Outpatier 28b. Time of		UA   4	I ☐ Nursing F	lome 5 Resi			cify)
Ing ling		0	27. Manner of Death 1 ■ Natural 5 □ Pending	28a. Date of Inju (Month, Da	y Year)	fn ury	м	28c. Injury at Work?	2 🗆 No	28d. Describe	now injury	OCCUITED	
VISION OF VITA  Attending Physicien: or death: ector: After this certition by the funeral director;		cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Pface of Inj	unc - At ho	me fam ctr			2 [] 140	28f Location (	Street and	Number or Ri	ural Route Number,
DIVISION OF  I or Attending Physeler death.  Director; After this all by the funeral director is a funeral director.		Certification:	4 ☐ Homicide determined	building, et	c. (Specify	y) (aiii, sti	eet, iactor	y, onice		City or To	wn, State)		5,471,001011001,
Division of Vital Re To the Hospital or Atending Physicien: The I within 24 hours eiter death. To the Funerel Director; Atler this certificate he completely filled in by the funeral director, page			29a. Certifier 1 Certifying Phys	ician: To the hest	of my kno	wiedae, deati	1 Occurred	at the time. d	late and place	and due to the	causa/s) a	and manner as	s stated.
Hos 24 h Fur etely		Medical	(Check only 2 Medical Examir one)	ner: On the basis of and manner st	f examinat	tion and/or in	vestigation	n, in my opinio	n, death occu	irred at the time,	date and p	place, and due	o to the cause(s)
To the P within 24 To the P		Me	29b. Signature and title of certifier 2				29	c. License nui			29d. Date	signed (Mont	th, Day, Year)
- s + ō				all		-		DS	1486	40	71	5/07	_
		1	30. Name and address person who co	mpleted cause of o	leath (Item	23a) (Tvne	Print)	-			-/		
10			De Tiello	13-1		2027 (1900)	60	2 At	bear	2 d B.	CIA	I N	1/21014
	Stat	e	31. Date filed (Month, Day, Year)	32. Registr	ar's Signa	ture	-			THE IN	- (1)	-	
Reg			.1111 0 6 20	107 Ang.	10.1	H. A	mast.	j					

DHMH 17 Rev 1/2001

07-05102 Bernard Galvin, Jr.

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

iaru Gaiviri, J		For State Critificate of Death	Reg. No.
- Physicia		Registrar  1. Decedent's Name (First, Middle,Last)	2. Date of Death  Month Day  Year  1719 hrs
xamin	-	n 1 D C-1in Ir	July 3, 2007
		4a. Facility Name (if not institution, give street and number)	ocation of Death
		Sinai Hospital Baitimore	If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year  Months Days	Foreign
Director		219-70-2438 1X M 2 F 49 Yrs. World Says	Hours April 20,1958 Country Maryland
	-	Usual Residence of Decedent	10d. Inside City Limits
any	4 4	10a. State 10b. County 10c. City, Town or Location	1 X Yes 2 No
* .	-	Maryland Baltimo	re 10g. Citizen of What Country?
nith the Maryland 5 23a or 28a-f show a 2 notified at once.		10f. Zip Code	
or 23	Ë	4422 Field Green Road 212	236 U. S. A.  Pagic Origin? / Specify Yes of No. 14. Race - American Indian, Black,
vith the s 23a s not		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hist	panic Origin? (Specify Yes or No- Mexican, Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.
death wi	Funeral	1 Never Married 2 X Married 1 V Ves 2 No	- " ""
ter de		2 Wildowed 4 Divorced If Yes, Give Year 1 Q 78-1984 1 Yes 2 X No	
11215-0036 dibe filed within 72 hours after fortal Hygiene, narked other fran "natural", event, the Medical Examiner	d b	45 Decedent's Education (Specify only highest grade completed) Toal Decedent's disdar occupant	
72 ho 1 "na al Ex	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+)	
136 thin ne.	ld I	12 + Real Estate	Agent Real Estate  18.Mother's Name (First, Middle, Maiden Surname)
5-0036 iled within 7 Hygiene. t other than	Ŝ	17. Father's Name (First, Middle, Last)	
21215-0036 und be filed within 72 Mental Hygiene. marked other than ic event, the Medical	Be	Bernard R. Galvin, Sr.	Colleen Berlin et and Number or Rural Route Number, City or Town, State, Zip Code)
21 oould d Me is ma	10	19a. Informatics Name/Actationing (1) per 11 C	reen Road, Baltimore, Maryland 21236
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teelth and Montal Hygiene. tent 27 is marked offer than "natural", or items 23a or 28a-f sho traumatic event, the Medical Extender must be notified at once			metery, Date 20c. Location - City or Town, State
nore, MD 2 ages I and 2 shoul nt of Health and M it: If item 27 is n other traumatic		20a. Method of Disposition  1	1
Pages Pages ment o tant:		4 Donation 5 Other Specify: Veterans Cemetery	07/09/2007 Owings Mills, Maryland
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Montal Hygient Important: If item 27 is marked other II injury or other traumatic event, the Medingry or other traumatic event e		22. Name and Address	s of Facility Schimunek Funeral Home Inc. r Road, Baltimore, Maryland 21236
<b>0</b> 89 13	1	29a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying	such as cardiac or respiratory arrest, shock, or heart Approximate Interval
rsician			
ical Examiner		Immediate Cause (Final disease a. Hypertensive Atherosclerotic Cardiovascular Dis	sease
LAAIIIIICI		or condition resulting in death)  Due to (or as a consequence of):	
	<u> </u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	
		cause. Enter Underlying Cause	
30. g . g	Examiner	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):	
executed executed and and and transit	1 #	d	
60, ate be execut shysician and	Medical	UNPENDED AMENDED	23d. Date of delivery
760, cate be	ا ع	FFEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3	Ectopic pregnancy Month Day Year
687 ertifi	i	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 5 Other (Specify)  1 Yes 2 No 9 Unknown 9 Unknown	
Box 687  Box etail  Box eartific  Box deartific  Box for use as the	19		e given in Part I. 23e. Did tobacco use contribute to the cause of death?
cords, P.O. Box 687/ aw requires that the death certifical issue been signed by the attending possible that the strenging possible the strenging possible that the strenging possible the strenging possible that the strenging possible that the strenging possible that the strenging possible that the strenging possible the strenging possible that the strenging possibl	[ A	Part II. Other significant conditions contributing to death but not resulting in the underlying cause	e given in Part I.  23e. Did tobacco use contribute to the cause of dectar.  1 Yes 2 V No 3 Probably 4 Unknown
P.O.	1	λα	Tes 2 VINO 3 Treatment
ds, squire sen si			autopsy prior to completion of cause of
SOFC law re			performed? death?  1 Yes 2 No 1 Yes 2 No
Division of Vital Records, rel or Attending Physician: The law requir rs after death.	airector, page	COUNTY TO See Lead 1 To See Lead 20 Plan 26.Plan 26.Pl	ace of Death (Check only one)
iam:	ector,	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3 DOA	Other: Nursing Home 5 Residence 6 Other:
of VI ing Physic	a a	a la divisa o No	njury at Work? 28d. Describe how injury occurred
Ing.	tune		Yes 2 No
VISIOF or Attendafter death Director:	y the	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office	be building, etc. 28f. Location (Street and Number or Rural Route Number, City
ViS or A after Dire	q I	1 Natural 5 Pending Investigation 2 Accident Suicide 6 Could not be determined (Specify)  1 Natural 5 Pending Investigation 28e. Place of Injury - At home, farm, street, factory, office (Specify)	or Town, State)
Spital spital sours	£ .	5 4 Homicide  29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time	e, date and place, and due to the cause(s) and manner as stated.
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be him 24 hours after death.	completely filled in by the	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time (Cheek anly one) Medical Examiner: On the basis of examination and/or investigation, in my opin one)	HOIL GOOD TO STATE OF THE STATE
Divis  To the Hospital or A within 24 hours after To the Funeral Dire	comp	and marrier stated. 29c. Lice	ense number 29d. Date signed (Month, Day, Year)
	1.5	29b Signature and title of certifier  O.	C.M.E. July 4, 2007
		( ) borbelly	
12+1		30. Name and address of person who completed cause of death (Item 23a)  Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Ba	altimore, MD 21201
log!		Laton Locke Wid. Tredistant Signature	
Reg			
1457		V V 10	

ORIGINAL

OCME

07-0	49	15	
Lisa	М	Hill	

isa M Hill	Sta 1- For State	te of Maryland		ment of icate of		and I	Menta	ıl Hygiene		20	07	2170
Physician/	Registrar  1. Decedent's Name (First, Middle	Last)	Certin	cate or	Dealii			2. Date of	Reg. I	No.	3. Time	of Death
/Physician Medical Examiner					Hill			Month June 2	28, 200	ay Year 17	0852	2 hrs
	I. isa 4a. Facility Name (if not institution	Marie give street and number	)	4	b. City, Tow		cation of I			4c. County of D	eath	
	Northwest Regional Ho	-			Randall	stown				Baltimore (	County	
Funeral	Social Security Number	S. Sex 7. Ag	je (In yrs. last b	oirthday)	If Under 1	Year	If Under 2	24Hrs. 8. Date	of Birth(N	MM/DD/YYYY) 9	. Birthplace (S	State or
Director		1 M 2 XF	41	Veo	Months	Days	Hours	Min. 09	28	65 F	oreign Country)	MD
	216-78-0275 Usual Residence of Decedent	1 M ZXF	41	Yrs.			100	0,5			,	
aux	10a. State 10b. County		10c. City, Tov	wn or Locatio	on						10d. Ins	de City Limits
	D-1	h		Owing	re Mi	111	3				1 🔲 Y	es 2 X No
Aaryland 28a-f show 1 at once.	MD Bal	timore		OWIII	10f. Zip Co				10a.	Citizen of What	Country?	
h the Maryland 3a or 28a-f sho otilis d at once.					·	2111	17	•		U.S.		
r death with the Maryland or items 23a or 28a-f sh must be notified at once Funeral Director	18 Champions	12. Was Deceden	Ever in II S	13 1//20				? ( Specify Yes	or No.		merican India	n Black
ath w tems	1 Never Married 2 Ma	ried Armed Forces	?					Puerto Rican, etc		White, e		.,
F. Pri		1 Yes 2	X No	1	Yes 2X	No s	specify:			Specify:	Black	
ural" min	45 Beerdeette Education (See	or Dates:	mpleted) 16					nd of work done	16	b. Kind of Busin		
2 hours a "natura" Exami	Elementary/Secondary (0-12)	College (1-4 or		during mo	st of working	g life. D	O NOT us	se retired)				
36 hin 7 edica	12th grade	na		Т	elle					Banl	Κ	
5-0036 led within 72 hour Hygiene, other than "natu the Medical Exan Completed	12th grade 17. Father's Name (First, Middle,	ast)					.Mother's	Name (First, Mic	ddle, Mai	den Surname)		
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than ic event, the Medical To Be Comple						(	Caro	lyn De	nni.	s		
ID 21215-C should be filed v and Mental Hygi 7 is marked oth natic event, the To Be Cc		ip (Type, Print )								r, City or Town,		
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygene.  unt: If item 27 is marked other than "naturial", or items 23a or 28a-f shour other traumatic event, the Medical Examinar must be notified at once To Be Completed by Funeral Director	Carolyn Hill	-Mother		18 C	hamp:	ion	ship	Ct, C	win	gs Mil	ls, Mo	21117
e, le, land land Healt item	20a. Method of Disposition		- 1	ce of Disposi natory or oth	tion (Name			Date	2	0c. Location - Ci	ty or Town, St	ate
nor ages nt of nt: If	1 Burial 2 X Cremation 4 Donation 5 Other Spi		late	-		orv	Inc	7/3/0	7	Baltim	ore, 1	1d
- 525	4 Donation 5 Other Sp. 21. Signature of Funeral Service I		meci	22. N	ame and Ad	ddress o	f Facility	*			-	
Balt permit. Depart Import	1 (Silve II	March		Ma	rch W	F/H	Wes	t Ba	1+i	more.	Md 2.	1215
Physician	23a. Part I. Enter the disease, or o	emplications that cause	d the death. Do	not enter th	e mode of	dying, su	ich as car	diac or respirato	ry arrest	, shock, or heart	Appro	ximate Interval
/Medical	failure. List only one cause of Immediate Cause (Final disease	a. Complicati	ons of a	omired	immume	def	icieno	v syndror	ne (A	ms)	Detwe	Death
taminer	or condition resulting in death)	Due to (or as a cons		e juii eu	LITTREE	J GCL	10101	o, Dinara				
	Sequentially list conditions,	b									- 12	
ner		Due to (or as a cons	sequence of):								11	
red Insit	(Disease or injury that initiated events resulting in death) Last	c.  Due to (or as a cons	sequence of):								-	
ansit E	events resulting in death) Last	d.										
e be executed spician and burial - transit edical Ex	X UNPENDED	AMENDED #23a,27,p	~ME ~966	0 7/13/	חייי לט							
60, te be hysici e buri	IF FEMALE:	#23a, 27, p			0/ 11					23d. Date of de	elivery	
). Box 6876 the death certificate by the attending phy ched for use as the Physician/M	23b. Was decedent pregnant in the past 12 months?			_	tal death	3	Ectopic p	pregnancy		Month	Day	Year
ox 6  th cel ttend ruse	1 Yes 2 No 9 Unk		at time of death	5 Ott	ner (Specif	y)			_			
Bc le dea little a	Tes 2 No 9 Onk	9 Unknown					- I- Dod	1 220	Did toba	see use contribu	ite to the cour	o of dooth?
Division of Vital Records, P.O. Box 6876 rat or attending Physician: The law requires that the death certificat rather death.  al Director: After this certificate has been signed by the attending phyled in by the funeral director, page 2 should be detached for use as the pertification: To Be Completed by Physician/M		ons contributing to dea	ith but not resu	iting in the u	naeriying c	ause giv	en in Pari	1. 23e.		acco use contribu	-	
aires d								-				
Records, The law requires ficate has been signage 2 should by Completed									Was an autopsy	pric	or to completic	dings available in of cause of
ecc he lav ate ha age 2								1 🗸	performe Yes 2		eth?  Yes	2 No
e C. p		7			26	Place o	f Death (C	Check only one)				
Vita	examiner?	Hospital: 1 / Inpat	ient 2 EF	R/Outpatient	3 DO	A O	ther <sub>4</sub>	Nursing Home	5 Re	esidence 6	Other:	
of of g Phy g Phy neral	27 Manner of Death	28a. Date of In (Month, Day		Bb. Time of I	njury 28	c. Injury	at Work?	28d. Des	cribe ho	w injury occurred	1	
Surface A Figure 1	1 X Natural 5 Pend	ing	, rear)			1 Ye	s 2	No				
isical isia	2 Accident Inves	tigation 28e. Place of	Injury - At home	e, farm, stree	et, factory, c	ffice bui	Iding, etc.			eet and Number	or Rural Rout	e Number, City
Division o Division o spital or Attending to the death. Ineral Director: After the filled in by the func	3 Suicide 6 Could deter	not be mined (Specify)						or T	own, Stat	te)		
Hospi		ysician: To the best of	ny knowledge.	death occur	red at the ti	me, date	e and plac	ce, and due to th	e cause(	s) and manner a	s stated.	
Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi  Medical Certification: To Be Completed by Physician/Medical Ex	one) 2 Medical Exam	niner:On the basis of ex	amination and/									s)
	29b. Signature and title of gertifie	and manner stated	1.		29c.	License	number		12	29d. Date signed	(Month, Day	Year)
	1 8/1///	1/1/V	1			O.C.M	.Ε.			June 29, 200	07	
	30. Name and address of person	who completed source of	death (Item 23	Ra)								
<b>d</b>		wno completed cause of Assistant Medical E		111 Pen	n Street.	Baltin	nore, M	ID 21201				
			ar's Signature									
State Registra	1111: 21 27 2	007	مرقع ميا	6004	E							

		1 - For State Registrar	State of M	laryland	-	artment <i>tificate</i>			ınd M		iene	007	2   7   0
Physici	an	Decedent's Name (First, Middle, Last)								2. Date of Dea Month	th Day	Year	3. Time of Death
/Medi	cal	Janice Barbara H  4a. Facility Name (If not institution, give s		-)		4h City 1	Town or	Location of	f Death	June	30,	2007 unty of Death	9:15 P M
Examir	ıer	9013 Forest Roa		,		4D. Oily,		rkvil	_		40.00		imore
Funeral		Social Security Number     6. Sex	M 2NE	ge (In yrs. la		If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day)	Year)	9. Birth	place (State or Foreign intry)
Director		215-52-4313 Usual Residence of Decedent	- 2M1	53	Yrs.					Sept. 7	, 195	3 M	aryland
yland how		10a. State 10b. County		10c. City,	Town or Lo	cation							10d. Inside City Limits
ith the Marylar or 28a-f ehow	ecto		imore		P	arkvi							1 Yes 2 No
with the	Dir	10e. Street and Number 9013 Forest Road				10f. Zip	212	3/4		1	0g. Citizen	of What Cou	intry?
deeth	Funeral Director		12. Was Deceden Armed Forces	t Ever in U.S	. 13. V	Was Deced			gin? (Spe	cify Yes or No- Rican, etc.)		Race - Amer	ican Indian,
s atter	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 🔯 If Yes, Give	No	1	ires,spec I∐Yes 2		Specify:	, Fuerto i	noan, etc.)		Black, White ecify:	
U. Z. I.Z. 13-0030 filed within 72 hours after deeth with the Maryland Hygiene. other than "natural", or Iteme 23a or 28a-f ehow ent, the Medical Examiner must be notified at	ed b	3 ☐ Widowed 4 ☒ Divorced	Year or Dates		16a. Deced	lent's Usua	l Occupa	tion		1		Wh of Business/Ir	ite
thin 72	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or	5+)	(Give	kind of wor OO NOT us	k done di e retired)	uring most	of workir	ng			,
led will her th.		12			Sa	les A						Bank	
d be fi	Be	17. Father's Name (First, Middle, Last)  Henry J. Hock								(First, Middle, I			
permit. Pages 1 and 2 should be filed within 72 hours atter deeth with the Maryla Department of Health and Mental Hygelene. Important: If Item 27 is marked other than "natural", or Iteme 23s or 28a-f ehove important: If Item 27 is marked other than "natural", or Iteme 23s or 28a-f ehoven privilengment of the marked other than marked than 10 met.  Once.	5	19a. Informant's Name/Relationship (Ty)	oe, Print)		19b. Mailin	g Address	(Street a			Route Number			p Code)
and 2 and 2 salth a n 27 is		Mary Anne Trollo	(Sister)						Park	ville,	Mary1	and 21	234
or oth		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ R	emoval from State	9	ice of Disport metery, crem							ion - City or T	
lit. Pa artmen ortant: injury		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service License	10	Sacr						/2007 _ .imunek			Maryland
Depa Impo eny ir		Buin a. L	ille							imunek altimor			
		23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on	cations that cause e caus and ach	d the death.	Do not ente	er the mode	of dying	, such as o	cardiac o	respiratory arr	est,		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition resulting in death)	300	UM	lo	len	na	_					Onser 2 Death
/Medical Examiner	Н	f accounty	Dur lo or a	s a conseque	ence of): ///	redi	y m	les e					5 M
	Je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Que to (or a	s a conseque	nes of):	210		va	-	T.A.			
be executed icien and burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	1/6	.66(									
rate be executed hysicien and the burial-transit	icai E		Due to (or a	s a conseque	ince or):								
Attending Physicien: The law requires that the death certificate rodath.  To death.  etter there this certificate hes been signed by the attending phys by the tuneral director, page 2 should be deteched for use as the						70000							
Bath certifica attending ph	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcom 1 ☐ Live birth			Ectopic pre	gnancy				23d.	Date of deliv	rery Day Year
res that the deatt	Physician/Med	1 Yes 2 No 9 Unknown	4☐Pregnant a 9☐ Unknown	at time of dea	ath 5□	Other (spe	city)					WORLD	Day Toal
s that i	by Ph	Part II. Other significant conditions con	tributing to death	but not result	ting in the un	nderlying ca	use give	n in Part I.		23e. Did to	pacco use o	contribute to	the cause of death?
w require been sig										1) (1)	s 2□N	o 3 Pro	bably 4 □Unknown
e lawr hes be je 2 sh	Completed									24a. Was a autops	y	prior to co	opsy findings available empletion of cause of
sicien: The certificate hi		05.19									No	death?	2□ No
ysicle is certi directo	o Be	25. Was case referred to medical examiner?  1  Yes 2 No	ospital:	ient 2∏E	R/Outpatien	t 3 🗆 DO		26. Place r: 4 🗀 Nur		Check only on		Other (Speci	(he)
ding Phys	Ju: T	27. Manner of Death 1 Natural 5 Pending	28a. Date of Inj (Month, D		8b. Time of		C. Injury	at		8d. Describe ho			•97
ttendii death. tor: A the tu	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	On Disco of la			М	1 🗆 Y	es 2 N		06 )			
al or A effect Direct d in by	Certification;	4 Homicide determined	28e. Place of Ir building, e	atc. (Specify)	ie, rarm, stre	eet, ractory,	опісе			City or Town	, State)	umber or Hur	al Route Number,
To the Hospital or Attending within 24 hours after death of the Funeral Director: After completely filled in by the tune	edicai C	29a. Certifier 1 Certifying Phys	ician: To the bes ier: On the basis and manner s	of examination	ledge, death on and/or inv	occurred a	it the time	e, date and inion, deati	d place, a h occurre	nd due to the ca	ause(s) and ate and pla	d manner as a	stated. to the cause(s)
To the within To the comple	Me	29b. Signature and title it certifier					License		′	2	9d. Date si	gned (Month,	Day, Year)
		WI WI HOW	MM				)40	316	V		DY	102	1200+
10		ame and address of person who co	mpleted cause of	death (Item 2	23a) (Type, !	Print /	ieer	red	Tree	t.Ba	et:	mae	MD 21201
Sta Registr		31. Date filed (Month, Day, Year)	32. Reg	trar's Signatu	J. A.	perte	9			1			12007 10 21201

DHMH 17 Rev 1/2001

Registrar DHMH 17 Rev 1/200

State

31. Date filed (Month, Day, Year)

0 6

LOWDER Registrar's Signature

07-05074	
James Hairston	

Please

Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.	2017	91.
State of Maryland / Department of Health and Mental Hygiene	2001	See 1

			1- For State Registrar				Cen	tificate c	f Death			Reg	No.		
	Physicia		1 Decedent's Nam	e (First, Middl	e,Last)	, ,	/					Date of Death Month	Day Y	ear	3. Time of Death
Me	dical Exami	ner	JAMES	· CL.	ay t	HAIR.	STON,	, Sr.			j	uly 2, 200		;ai	2337 hrs
*			4a. Facility Name (	if not institution	n, give stree	et and numb	oer)		4b. City, Town, Baltimore		of Death		4c. County	of Death	
	Europel		5. Social Security		6. Sex	7	Age (In yrs. Ia	st birthday)	If Under 1 Y		der 24Hrs. 8	. Date of Birth	(MM/DD/YY)	(Y) 9. Birth	nplace (State or
	Funeral Director		215 14 39		1 X M		42	Yı	Months D	ays Hour		Sct. 18.	1964	Foreign	
tyle egyne, alace	te a war e beigner		Usual Residence of				Lio. ou					- 00			10d. Inside City Limits
0	nd show any ice.	_	Morul	10b. County	NIA		Toc. City,	Bal.	HHORE			•		21	1 Yes 2 No
	after death with the Maryland al", or items 23a or 28a-f show ner must be notified at once.	Director	10e. Street and Nu	mber A	1 54	VE 2 F	# 801		10f. Zip Code	120	2	10	g. Citizen of V	What Coun	try?
	ath with t tens 23a	Funeral	11. Marital Status  1 Never Marri	ed 2 M		Was Deced Armed Forc	ent Ever in U.s		as Decedent of Yes, specify Cub	Hispanic Or	rigin? ( Specif			ce - Americ nite, etc	can Indian, Black,
april . The state of the state	after death	by Fu	3 Widowed		orced If Yes	ates:	2 No	1	Yes 2					Bla	
	hours 'natur Exam		15. Decedent's E					during	ent's Usual Occup most of working I	ife. DO NO	T use retired)	done	16b. Kind of I	3usiness/Ir	dustry General
	5-0036 ed within 72 hours after tygiene. other than "natural", the Medical Examiner	Completed	Elementary/Sec	ondary (0-12)	C	College (1-4	or 5+)	Lot	TECH	NIC	ini		Husp		
	21215-0036 uld:be filed within 7 Mental Hygiene. marked other than c event, the Medica	S	17. Father's Name	(First, Middle,	, Last)	/	<u></u>	-		18.Mothe	er's Name (Fi	rst, Middle, M	aiden Surnan	ne)	
21	21 ( be fill ontal F irked	Be	JAMES	C. H	AIRS	for	15.			n	laric	Cla	rk		
	sho and zis	To	19a. Informant's N	ame/Relations	ship (Type, F	rint)	1 THEN	19b. Maili	ng Address (St	reet and Nu	Drive				Zip Code)
	- D# E Z		20a. Method of Dis		KOTT		20b. F	Place of Disporter	osition (Name of		į D	ate	20c. Locatio	n - City or	Town, State
	Baltimore, permit. Pages lar Department of Hee Important; If ite injury or other tr		1 Burial 2 4 Donation 5		n 3 Re	emoval from	State	One III	LA C	neka.	7/9	167	Brok	lens.	Marylow
	Baltir permit. F Departme Importai		21. Signature of Fu	Other Sunder Sunder Service			COL	22.	Name and Addr	ess of Pacil	ity CNP	TOTAL	- Um	15 FZ.	Marylows
	Der Der		Low	H	Tu			5.	240 KG	LITE	rstain	, Kel	Balto	ser ,	Red 2124
~	Physician	1	23a. Part I. Enter t	he disease, or nly one cause	complication	ns that cau	sed the death.	Do not enter	the mode of dyi	ng, such as	cardiac or re	spiratory arre	st, shock, or I	neart	Approximate Interval Between Onset and
	/Medical `xaminer		Immediate Cause	(Final disease			clerotic	cardio	ascular d	is-asc					Death
			or condition result		Due to	o (or as a co	onsequence of	f):			I della				
		ner	Sequentially list or if any, leading to it	mmediate		o (or as a co	onsequence of	f):		710	E1.11				
8		Examiner	(Disease or injury	that initiated	C	o (or as a co	onsequence of	f):			_				<del> </del>
$\sim$	ecuted and transit		events resulting in	deam) Last	d										
9690	ज्ञ ङ	/Medical	X UNPENDE	)	X #Y	ENDED 2	7.perME.	<b>≥869.</b> 7/	/27/07 TT						
9	1760, ficate be exe g physician a	Me	IF FEMALE:		23	c. If yes, ou	tcome of pregi	nancy						of delivery	
13	687 sertification	ian/	23b. Was deceden past 12 month		1 '	Live birt	h nt at time of de	2 F	etal death	3 Ector	pic pregnancy	У	Month		Day Year
-40	Box 687 e death certificathe attending	Physiciar	1 Yes 2	No 9 Un	known g	Unknow		ath 5	Other (Specify)				1		
.3	O. Bo at the dea d by the a stached fo		Part II. Other sign	ificant condi				esulting in the	e underlying caus	se given in I	Part I.	23e. Did tol	pacco use co	ntribute to	the cause of death?
	ords, P.C w requires that as been signed I should be deta	d by						_				1 Yes	2 No	3 Prob	oably 4 🗸 Unknown
-	rds requi been	ete										24a. Was a			topsy findings available completion of cause of
1	Records, The law require ficate has been si	Completed									-	perform	med?	death?	
#	/ital Rec ystcian: The his certificate director, page		25. Was case refe	rred to medica	al				26.Pl	ace of Deat	th (Check onl		. NO	1 0	2 10
	'ital sician is ceri	Be	examiner?		Hospit	al: 1 Inc	patient 2	ER/Outpatie		Other <sub>4</sub>	Nursing H		Residence 6	Other	<del></del>
	1 of V ding Phy After thi funeral d	- To	1 Yes 27. Manner of Dea	2 No	2	28a. Date of	Injury	28b. Time o		Injury at Wo		d. Describe h		L. married	
	ion (tending eath.	흲	1 X Natural		ding	(Month, D	Day,Year)		1	Yes 2	No				
	Division of Vital tal or Attending Physician: ns after death.  al Director: After this certiled in by the funeral director	fica	2 Accident 3 Suicide		estigation	28e. Place	of Injury - At h	ome, farm, st	reet, factory, office	ce building,	etc. 28			nber or Ru	ral Route Number, City
	Div spital o	Certification;	4 Homicide			(Specify)						or Town, St	ate)		
1i	Division of Vital Records, P.O. Box 68 To the Bospital or Attending Physician: The law requires that the death certi- within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical C	29a. Certifier 1 (Check only one) 2	Certifying P	aminer:On t	he basis of	examination a	ge, death occ nd/or investig	curred at the time	e, date and paid and	place, and du occurred at th	e to the causone time, date a	e(s) and mani and place, an	ner as state d due to th	ed. e cause(s)
C	To To com	Med	29b. Signature an		and	manner sta	ted			ense numbe					nth, Day, Year)
			All.	hin	1011	MY	7		0.	C.M.E.			July 3, 2	007	
			30. Name and add	iress of persor	n who compl	leted cause	of death (Item								
0_1			Melissa Br			4	ical Examir		Penn Street	, Baltimo	ore, MD 21	1201			
	S Regis		31. Date filed (Mo	nth, Day,Year)	6 2007	32. i gi	istrar's Signatu	D B	perk						
				002											

Douglas Harris 07-05018 UNK UNK

NK UNK		1- For State	of Maryland / Dep	ertificate of i		i wentai n		200	7 2 171
Physicia	ın/	1. Decedent's Name (First, Middle,Las	et)	11.	20:0	i	2 Date of Death		3. Time of Death 0610 hrs
Medical Exami	ner	4a. Facility Name (if not institution, give	(e street and number)		RRIS . City, Town, or L	ocation of Death	Month July 1, 200	7 4c. County of Deat	
)		5100 Baltimore National F			Baltimore Cit			Λ.	I/A
Funeral		Social Security Number     6. S	ex 7. Age (In yrs	s. last birthday)	If Under 1 Year	If Under 24Hrs		Forei	rthplace (State or
Director		011 00 10 11	M 2 F (	32 Yrs.	Months Days	Hours Min	MAV 15	1975 0	ountry) MARILLAND
any		Usual Residence of Decedent  10a. State 10b. County	10c. Ci	ity, Town or Location	1		. /		10d. Inside City Limits
	Ļ	MADVIAND	IA		BAIT	7 HORE	- CIT	7/	1 X Yes 2 No
Maryland 28a-f show d at once.	Director	10e. Street and Number	,,,,		10f. Zip Code	,,,,,,	19	g. Citizen of What Cou	untry?
with the Maryland ns 23a or 28a-f sh be notified at once		1615 RIGG.	S AVENUE		0	2121	7	45A	
ath with the items 23a	uneral	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in Armed Forces?	If Yes	Decedent of Hisp s, specify Cuban,			14. Race - Ame White, etc.	rican Indian, Black,
fter de	╙		1 Yes 2 No		es 2 X No	specify:		Specify: B	LACK
iours a	eted by	15. Decedent's Education (Specify of			Usual Occupation			16b. Kind of Business	
DO36 within 72 liene. eer than "1	plet	Elementary/Secondary (0-12)	College (1-4 or 5+)		-	7 , 4/= /,)	NED	MANUTAR	2.0.10 Ma
5-00 iled with Hygiene I other t	Comple	17. Father's Name (First, Middle, Last	)	19 03e	MBLY 1	8.Mother's Name	e (First, Middle, M	MANUFAC aiden Surname)	KIKING CO.
	a	DOUGLAS	L. HAR		R.	<u> </u>	LENE	BR	SWN _
imore, MD 2121 Pages I and 2 should be fi nent of Health and Montal lant: If item 27 is marked or other traumatic event,	٩	19a. Informant's Name/Relationship (	Type, Print )	19b. Mailing	7 /		Rural Route Numl	per, City or Town, Stat	e, Zip Code).
ore, ME ss I and 2 s of Health au If item 27 her traums		20a. Method of Disposition		b. Place of Dispositi			Date	20c. Location - City o	r Town, State
more sages lent of l		1 Surial 2 Cremation 3 4 Donation 5 Other Specify		crematory or othe		EDU 17-	17-07	1 ANSMI	WE MA.
Baltimore, MD permit. Pages I and 2 sho Department of Health and Important: If item 27 is injury or other traumati	1	21. Signature of Funeral Service Lice			me and Address		BRKINN	JR, FUN	ERAL HOME
	0 /3	2 a. Part I. Ehjer the disease, or com	16 110a	10 21	40 N. 1	CULTON	AVE		40 2/2/7 Approximate Interval
Physician /Medical	. 1	failure st only one cause on e	ach line.	atii. Do not enter the	midde of dying, s	Suci as cardiac c		st, shock, or near	Between Onset and Death
xaminer	1	Immediate Cause (Final disease a r condition resulting in death)	Multiple Injuries  Due to (or as a consequence	e of):					
en and	1	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence	e of/:					
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated							
A ted		events resulting in death) Last	Due to (or as a consequence	e of):					
Ox 68760, eath certificate be executed a strending physician and for use as the burial - transit	Medical	UNPENDED	AMENDED						
Records, P.O. Box 68760, The law requires that the death certificate be icate has been signed by the attending physicipage 2 should be detached for use as the buring.		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pr			F- 4	-	23d. Date of delive	
Box 687 death certific the attending p	cian	past 12 months?	1 Live birth Pregnant at time of	1	Ideath 3 ∟ er (Specify)	Ectopic pregna	ancy	Month	Day Year
Bo) ne death the att	Physician/	1 Yes 2 No 9 Unknow	9 OHKHOWH						( ) " (
ires that the signed by	ā	Part II. Other significant conditions	contributing to death but no	ot resulting in the un	derlying cause gi	iven in Part I.		2 ✓ No 3 Pro	
ords, w requires s been sig	Completed						24a. Was a		utopsy findings available
Division of Vital Records, tal or Attending Physician: The law requir rs after death.  al Director: After this certificate has been seen is the funeral director, page 2 should	Idm			· · · · ·	<del></del>		autops perform 1 Yes 2	ned? death?	completion of cause of 'es 2 No
tal Rec	0	25. Was case referred to medical				of Death (Check			
n of Vital ding Physician: n. After this certif	To B	1 ✓ Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient				Residence 6 🗸 Othe	er: Scene
n of hiding Ph.		27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month Day, Year) Jul 1, 2007	28b. Time of Inj 0600 hrs	·   - · ·	y at Work? es 2 ✔ No		ow injury occurred uto truck s collisi	on
isior Attender death	icati	2 Accident Investigat	28e Place of Injury - A	t home, farm, street			28f. Location (S	treet and Number or R	ural Route Number, City
Divis pital or At ours after d teral Direct filled in by	Certification	Suicide 6 Could not determine		oad / Highway			or Town, St 5100 Baltimore	ate) e National Pike Rou	te 40 We, Baltimore Ci
Division To the Hospital or Attent within 24 hours after death To the Funeral Director:		Condex only	ian: To the best of my knowl						
To th withir To th compl	Medical	29b. Signature and title of certifier	r:On the basis of examination and manner stated.	and/or investigation	29c. License		at the time, date a	29d. Date signed (Mi	
0.1146		NV 11/1 x	IN M		O.C.N			July 2, 2007	
To A		30. Name and addless of person who	completed cause of death (It	em 23a)				-	
-2			istant Medical Examin		Street, Baltin	more, MD 21	201		
St Regist	ate	31. Date filed (Month, Day, Year) 21	32 Registrar's Sign	S. Loss	E .				

2007 21714

DOME

Vi	ncent	Roger	Hewitt,	Sr.

Registrar

Red	or State Certificate of Death	Reg. No. of Death th Day Year 1715 brs
ysician/ 1. _xaminer	Vincent Roger Hewitt Sr. July	3, 2007
4a	Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death	4c. County of Death  Anne Arundel
	8892 Ft. Smallwood Rd.	ate of Birth(MM/DD/YYYY) 9. Birthplace (State or
differen	Social Security Number 16, 36X	4/24/1944 Foreign Country) MD
	ual Residence of Decedent a State 10b. County 10c. City, Town or Location	10d. Inside City Limits
8 1 10	Dacadona Pacadona	1 Yes 2 X N
alt; or items 23a or 28a-f she iner must be notified at once by Funeral Director	e Street and Number	10g. Citizen of What Country?
23a or 28a-f show a notified at once.	3892 Ft Smallwood Road 21122	USA  Ves or No- 14, Race - American Indian, Black,
ns 23a be noti	. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? ( Specify Y if Yes, specify Cuban, Mexican, Puerto Rican,	
or items 23 must be no	Never Married 2 X Married 1 Yes 2 X No 1 Yes 2 V No specify:	specify: White
by By	Widowed 4 Divorced It res, Give in or Dates:  15. Decedent's Education (Specify only highest grade completed)  16. Decedent's Usual Occupation (Give kind of work doduring most of working life. DO NOT use retired)	one 16b. Kind of Business/Industry
tygiene. other than "natu he Medical Exan Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	A1 Septic
iene. Medica	12 Owner 18 Mother's Name (First,	, Middle, Maiden Surname)
Hygiene.  t, the Medical Exam  Completed 1	7. Father's Name (First, Middle, Last)  Fugoro / Hewitt  Dorothy	Anthony
0 2 2 E   W	Pa informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or Rural F	Route Number, City or Town, State, Zip Code)
27 is r matic	Jackie L. Hewitt (spouse)   8892 Ft Smallwood Road,	T Ot-1-
Health item	0a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other place)  3 00 00 00 00 00 00 00 00 00 00 00 00 00	09
of it age	Other Specify: • Gien Haven Cemetery 200	
rmit.	11. Signature of Funeral Service Licensee 3111 Mountain Road.	lings Funeral Home, P.A. Pasadena, MD 21122
sician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or responding.	oiratory arrest, shock, or heart Approximate Inter Between Onset a
Cammer	a. Hypertensive cardiovascular disease or condition resulting in death)  a. Hypertensive cardiovascular disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):  Due to (or as a consequence of):	
e be executed ysician and bunial - transit	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  d.	
e be execut ysician and burial - tra ledical	X UNPENDED AMENDED, PII, 27, perME, g869, 7/10/07 TI	23d. Date of delivery
÷ ~ 0 5	IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Pregnant at time of death 5 Other (Specify) 9 Unknown	Month Day Year
the death certificate yy the attending phy ched for use as the Physician/M	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death
es that igned be be deta	Chronic alcohol use	0 P
he law requires ate has been sig age 2 should be		24a. Was an autopsy autopsy performed? 24b. Were autopsy findings ava prior to completion of cause death?
e taw e has ge 2 sl	V + +	1 Yes 2 No 1 Yes 2 No
mr. The striffical tor, pa	25. Was case referred to medical 26. Place of Death (Check only	
ysicia phis cel direct	examiner?  1  Yes 2 No    Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other   Nursing H	id. Describe how injury occurred
After t	27. Manner of Death  28a. Date of Injury (Month, Dey, Year)  1 Yes 2 No	
private of Attending Physician; The law requires that the spiral or Attending Physician; The law requires that the nours after death.  Intent Director; After this certificate has been signed by filled in by the funeral director, page 2 should be detacted in by the funeral or to be Completed by F.	1 X Natural 5 Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28	St. Location (Street and Number or Rural Route Number
after after the bire of in b	3 Suicide Could not be determined (Specify)	or Town, State)
lospits 4 hours unera ly fille	4 Homicide	ue to the cause(s) and manner as stated.
To the Hospital or Attending Physician; The law requires that the de within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completedy filled in by the funeral director, page 2 should be detached in Medical Certification: To Be Completed by Phy	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, ceath observe	29d. Date signed (Month, Day, Year)
A P P P P P P P P P P P P P P P P P P P	29b. Signature and title of certifier  29c. License number  O.C.M.E.	July 4, 2007
	Carre Hares	
	30. Name and address of person who completed cause of death (Item 23a)  Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
	Callot Atlant, IVID 7 (Collection Collection Connecting)	
State Registra	St. Date lifet (Wolfm) 2017	AALIE .

**ORIGINAL** 

			1- State of Maryland / Department of Certificate of Registrar		ntal Hygien Reg. N	C U U I	21715
			Decedent's Name (First, Middle, Last)		. Date of Death		3. Time of Death
	Physici		BERTHA S. HARMAN	.	Month D	2007	8:20 P <sup>M</sup>
	/Medic Examin			, or Location of Death		c. County of Death	0.20 1
	LAdiiiii	Ç.	CARROLL LUTHERAN VILLAGE WESTM	INSTER		CARROLL	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Yea	ar If Under 24 Hrs. 8	. Date of Birth	0 Right	place (State or Foreign
	Director		218-62-5815 1 M 2 MF 101 Yrs. Months Days		(Month, Day, Yea	OF WEST	VIRGINIA
	ס		Usual Residence of Decedent		0/30/19	05 11101	VIIIOIIIII
	ylan how		10a. Slate 10b. County 10c. City, Town or Location			1	0d. Inside City Limits
	a-f-e	ctor	MD CARROLL WESTMINSTER				1 X Yes 2 ☐ No
	or 28	ire	10e. Street and Number 10f. Zip Code	)	10g. C	itizen of What Cou	ntry?
	within 72 hours after death with the Maryland ene. Than "naturel" or Iteme 23e or 28e-f ehow he Madical Examiner must be notified at	by Funeral Director	205 ST. MARK WAY, APT. 503 211	58	τ	JSA	
	dea	ner	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Armed Forces? 13. Was Decedent of If Yes, specify Cu	f Hispanic Origin? (Speci uban, Mexican, Puerto Ric	y Yes or No-	14. Race - Americ Black, White,	
စ္	or It	F	1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No		Jul., 5.5.,		
215-0036	irel',	d b	Widowed 4 □ Divorced Year or Dates:			Specify: WHI	LTE
Ϋ́	72 h	Completed	15. Decedent's Education 16a. Decedent's Usual Occi (Specify only highest grade completed) (Give kind of work don	e during most of working	16b.	Kind of Business/In	dustry
<u>2</u>	hen hen	ld m	Elementary/Secondary (0-12) College (1-4or 5+) life. DO NOT use retir	red) ACHER	ED	UCATION	
2	filed v Hygie other t	ပိ	12 4				
E C	be fi	Be	17. Father's Name (First, Middle, Last)  JAMES SITES	18. Mother's Name (I	-irsi, middie, maide LA JUDY	an Sumame)	
aryland	should and Men	P					
B	12 st h and 7 te r		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street				
e)	1 and 1 and 1 ealth 1 m 27 1 her tu		SUE H. GREEN - DAUGHTER 231 De Guy 20a. Method of Disposition (Name of	Avenue, I		PA 17 Location - City or To	
Ö	Pages nent of h int: if its iry or of		1 ☐ Burial 2 X Cremation 3 ☐ Removal from State cemetery, crematory or other pl	lace)			
altimore,	tant:	١,	4 □Donation 5 □Other (Specify) ALL COUNTY CREM			ESVILLE	
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Menth Hygiene. Department of Health and Menth Hygiene. Department of Health and Menth of their than "naturely or Iteme 23a or 28a-f show eny Injury or other traumatic event, the Madical Examinar must be notified at ODGs.			ress of Facility FLET			
_	do = e d		23a. Part1. Enter the disease, or complications that caused the death. Do no, 3 ter the mode of do	AIN ST., V		STER, MD	
			shock or heart failure. List only one cause on early line.	1 /1/		-	Approximate Interval Between Onset and Death
	Pnysician	1	Immediate Cause (Final disease or condition as a final disease or condition	ufficio	ne,		Leave
1	/Medical Examiner		resulting in death)  Due o (or as a consequence of):	17/1	Y		
١.	_,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	L	Sequentially list conditions, b.	///			-
9	be tis	ine	if any, leading to immediate cause. Enter Underlying Cause (is as a consequence of).				
0	and and I-tran	Examiner	that initiated events c. resulting in death) Last Due to (or as a consequence of);				
8760,	ficate be executed physicien and s the burial-transit						
387	phys s the	dicai	d.				
×	death certiff e ettending id for use as	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			22d Data of dally	
Вох	eath certif ettending for use as	ian	in the past 12 poinths?			23d. Date of delive Month	Day Year
o.	he d	Physician/Me	1 ☐ Yes 2 No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown				
<b>a</b>	The law requires that the death certif te has been signed by the ettending rage 2 should be detached for use at	F.	Part II. Other significant conditions contributing to death bull not resulting in the underlying cause of	given in Part I.	23e. Did tobacco	use contribute to the	ne cause of death?
Records,	sign d be	d by	Hapontonion		1 ☐ Yes	2 □No 3 □ Prob	ably 4 Unknown
င္က	w require been si should I	ete	TATE CONTIN		04-145	0.45 .W	
ě	has ge 2	Completed	Denoma		24a. Was an autopsy performed	prior to co	psy findings available impletion of cause of
a					performed 1 □ Yes 2 N	lo 1 ☐ Yes	20 No
⋚	Physicien: The Ithis certificate har all director, page	Be	25. Was case referred to medical examiner?  Hospital:	26. Place of Death (0			
Division of Vital	ਦੂ ≑ ਫ਼	5 T	1 Inpatient 2 EH/Outpatient 3 DOA	4 Nursing Home	5 Residence d. Describe how inj	6 Other (Specif	y)
5	Attending I r death. ector: Atter by the funer	Tion I	1 Natural 5 Pending (Month, Day Yeer) Injury W	ork? □Yes 2□No	2. 2000/100 11011 111	ary occurred	,
S	i or Atten af er deat Director: i ir by the	fica	3 ☐ Suicide 6 ☐ Could not be 28e Place of Injury - Al home farm, street factory office		Location (Street :	and Number or Rura	I Route Number
<u>≥</u>	affer Dire	Certification;	4 Homicide determined 286. Place of injury - A nome, farm, street, factory, office building, etc. (Specify)		City or Town, Sta	te)	
_	Hospital 24 hours a Funeral E stely filled		29a. Certifier 1 Certifying Physician. To the best of my knowledge, death occurred at the	time, date and place, and	dua to the raus-	5) and manner as s	tated.
	To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the	Medicai	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my one)	opinion, death occurred	at the time, date a	nd place, and due to	the cause(s)
	To the vithin 2. To the complete	Me	29b. Signature and title of certifier 29c. Licer	nse number	29d. D	ate signed (Month,	D. Year)
			Dypinto NO. 110	00559	42 1	1/5/	20014
		1	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	113	" L	12/9	201
	2		KEIN O BREWSTER BROFREGER	55 11	JE BE	20 M	121780
			31. Date filed (Month, Day, Year) 32. Registrar's Signature			VII	11/1/
	Sta	τe					1

DHMH 17 Rev 1/2001

ORIGINAL

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** CATHERINE HELEN HERRING JULY 4:30 2007 3 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WESTMINSTER CARROLL 3034 OLD WASHINGTON RD. If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 M 2 F Director 218-09-9228 87 7/02/1920 MARYLAND Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show Examiner must be notified at 1 X Yes 2 □ No MD CARROLL WESTMINSTER Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5 TIMBER RIDGE DR. items 23a 21157 51 USA Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. nt: If Item 27 Is marked other than "natural", or items 23 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: WHITE þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ASSEMBLER MANUFACTURING 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be WILLIAM FROMM MARY EVA WAGNER ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 1 1 5 7 19a. Informant's Name/Relationship (Type. Print) - DAUGHTER 3043 OLD WASHINGTON RD., WESTMINSTER, MD PATRICIA CHANEY 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any injury or ot once. 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State SOUTH CARROLL CREMATORY 7/8/07 Winfield, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility FLETCHER FUNERAL HOME, P.A. 21. Si nature of Funeral Service Licensee 254 E. MAIN ST., WESTMINSTER, MD 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner poalhun Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Verys Thrombos or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 ☐ Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 ☐ Yes 2 ☐ No 3 Probably 4 □Umknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an cate has autopsy perform 1□ Yes 2 17 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) UGHTER 'S 1 | Yes 2 No 2 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) in by t 4 ☐ Homicide 1 🖵 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

Registrar DHMH 17 Rev 1/2001

the

State

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

onel

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

R. Perman R. Kanena Rue Kaneng 32 Registrar's Signature 2007 06

**ORIGINAL** 

29c. License number

29d. Date signed (Month, Day, Year)

Malenty dure west ministy

State of Maryland / Department of Health and Mental Hygiene-

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Vaar HANSEN 10:30P **Physician** 2007 Ltek /Medical 4c. County of Death 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) Examiner NIA VA MediCAL C enter BALTIMORE BALTIMORE Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Mar.5,1931 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Months Days 1⊋M 2□F 218-26-6750 76 Yrs. Maryland Director Usual Residence of Decedent 10d Inside City Limits with the Maryland 10a. State 10b County 10c. City, Town or Location the Medical Examiner must be notified at 1X Yes 2 □ No Director Md. Baltimore City n/a 28a-f 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number ŏ 108 South Collington Avenue 21231 U.S.A. 238 death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? V⊆|Yes 2 □ No If Yes, Give Year or Dates! 952-54 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 5 Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 XNo Specify: Specify: þ 3 Widowed Wivorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Colfege (1-4or 5+) Il Hygiene. other than Tile Setter Construction 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any ling yor other traumatic event pice. Charles Walter Helen Cwalina Hansen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8009 Shore Road Baltimore, Maryland 21222
Los of Disposition (Name of Date 20c. Location City or Town, State Calvin York-Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Surial 2 Cremation 3 Removal from State Holy Cross P.N.Cem 7-7-2007 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Raczorowski Funeral Home, FA 21. Signature of Funeral Service Licensee 1201 Dundalk Ave. Baltimore, Maryland21222 Approximate fnterval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. fmmediate Cause (Final disease or condition resulting in death) **Physician** Myocarcha /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of): Examiner physicien and the stranger or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 3 Probably 4 Onknown 1 ☐ Yes 2 ☐ No cate has been sig. , page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 Yes 2OMo 2 1 No Be 25. Was case referred to medical 26. Pface of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☑ ER/Outpatient 1 ☐ Yes 2 ☐ No 3 DOA Certification: To After this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 1 Natural 5 Pending investigation after death.

I Director: Aft
d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide within 24 hours a To the Funeral C Hospital 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 19864 no completed cause of death (Item 23a) (Type, Print) 30. Name and address of parso 10 North GREENS STREET BALL MULO MI) 25 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 0 6 200 Registrar

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	Examir Funeral Director		4a. Fecility Name (If not institution, give street Name (If not institution), give street Na	eet and number)  WSING HOME  7. Age (In yrs. last birthda)  1 2 F S Yrs.	4b. City, Town, or Location of Death    Jour Son	8. Date of Birth (Month, Day, Yes	4c. County of Death  Battimere  9. Birthplace (State or Foreign Country) Virginia
	Maryland :- f show	tor	Usual Residence of Decedent  10a. State 10b. County  Mary and NA	10c. City, Town or	Location		10d. Inside City Limits 1 107 Yes 2 □ No
	h with the 3a or 28a at Le r ct	ai Director	10e. Street and Number 5222 Transo	re Rd.	10f. Zip Code 2/2/4	10g. (	Citizen of What Country?
036	hours after death with the Maryland tural', or items 23a or 28a-f show al Examinat he rolling a	by Funerai	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	Was Decedent Ever in U.S. Amed Forces?  1为Yes 2 □ No 19 44 − If Yes, Give Year or Dates: 1946	. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 1 ☐ Yes 2 No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black
21215-0036	be filed within 72 hours ital Hygiene. Id other than "natural", event, Ira Medical Ens	Completed	15. Decedent's Educat (Specify only highest grade of	ompleted) (Giv	redent's Usual Occupation re kind of work done during most of wor DO NOT use retired)  AC ENGINCEY	king T	Kind of Business/Industry & Colfinsore City Whic Schools
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-	1 and 2 sho Health and em 27 is m ther traum		19a. Informant's Name/Relationship (Type,  Marsha Turnip Sec.  20a. Method of Disposition	d/Daughter 522		Baltinor	m 1 1 21214
Baltimore	permit. Pages Department of i Important: If it any injury or o		1 Seurial 2 Cremation 3 Rem 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	Garnsc .	A FOREST VET Cen 22. Name and Address of Facility Cha	atmon-Ha	vings Mills MD ris Funcal Home are MD 21206
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Ö	To the Hospital or Attenc within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Physic	ian: To the best of my knowledge, de	ath occurred at the time, date and place investigation, in my opinion, death occu	, and due to the cause	(s) and manner as stated.
	To the H within 24 To the F complete	Medical	29b. Signature and title of certifier	and manner stateet	- , ,		Date signed (Month, Day, Year)
le	, T		30. Name and address of person who comp	pleted cause of death (Item 23a) (Type		Drive	12/04 12/04
	Sta Registr		31. Date filed (Month, Day, Year)	2. Registrar's Signature	Wall	) 1VV ) Z	

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			Registrar  1. Decedent's Name (First, Middle, Last)		Jerunicale or i		2. Date of Deat	eg. No.	3. Time of Death
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	pug M		Usual Residence of Decedent  10a. State 10b. County 1	I0c. City, Town	or Location				10d, Inside City Limits
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336	d within 72 hours after death with the Maryland jene. r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced  12. Was Decedent Every Armed Forces?  1 □ Yes 2 ☒ No If Yes, Give Year or Dates:		13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2X No	Ispanic Origin? (Spec an, Mexican, Puerto F Specify:	Rican, etc.)	Black, Whit	
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Division or	l or Atter after de Directe I in by t	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury building, etc.	r - At home, farr (Specify)	m, street, factory, office	2	8f. Location (Si City or Town	treet and Number or R n, State)	ural Route Number,
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifical completely filled in by the funeral director,	Medical C	29a. Certifier (Chack only one)  1 Certifying Physician: To the best of eand manner state and manner state	examination and	death occurred at the ti /or investigation, in my o	me, date and place, a ppinion, death occurre	and due to the c	ause(s) and manner a date and place, and du	s stated. e to the cause(s)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** TASPER 1922 PM PATRICIA June 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Randallstown Baltimore HOSPITAL Northwest Center 9. Birthplace (State or Foreign Country)
North Carolin a If Under 1 Year | If Under 24 Hrs. 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year Days 1 □ M 2 🕽 WKN Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 No 2 No Be Completed by Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2 14. Bace - American Indian Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Newer Married 2 Married 1 ☐ Yes 2 ☐ No Specify: 3 ₩Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DQ NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) UKN 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Jacquele Date 20b. Place of Disposition (Name of 20a. Method of Disposition 20c\_Location - City or Town, State cemetery, crematory or other place, 1 Surial 2 □ Cremation 3 Removal from State 4 Domation 5 Other (Specify) JULY & 2001 ure of Funeral Service Licensee 22. Name and Address of Facil 2122 reto. md Nancy M. Wallece Funeral elae Park Enter he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he in failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause Final disease or condition resulting in death) Atherosclerotic Coronary VAScular Disease Due to (or as a consequence of) Sequentially list conditions, if any, leading to infine anatocause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 No 3 Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy perform 1 Yes 2 2 **X** No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 🔲 Inpatient 2 R/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Physician: The law requires that the death certificate be executed and burial-tra P.O. Box 68760. physician the as attending esn for ed by the a signed to Division or Vital Records, page 2 should certificate has director this After

**Funeral** 

Director

r 28a-f show notified at

1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. em 27 is marked other than "natural", or items 23a or 28a-f show

Maryland 21215-0036

Baltimore,

Pages 1

**Physician** /Medical

Examiner

important: if item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be

Physician/Medical Completed by Be

Medical Certification: To

Hospital or Attending ithin 24 hours after death.

the Funeral Director: A

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death.

State Registrar

29b. Signature and title of certified HRISTINE

4 Homicide

29a. Certifier

BRAUD, mo

29c. License number D0057634

🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

2007

30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

Randallstown, mD RUAD 5401 OLD COURT

31. Date filed (Month, Day, Year)



			1 - For State Registrar	_		Depa		ealth and	I Mental Hyg		007	21721
	Physic		Decedent's Name (First, Middle, Las Jack R. Johnson						2. Date of Dea June		20Ŏ <sup>9ar</sup>	3. Time of Death 10:30 A. M
	/Medi Examir		4a. Facility Name (If not institution, give Manor Care Ruxton	street and number	)		4b. City, Town, or Baltimor		ath		ounty of Death	
	Funeral Director		003-24-1000		ge (in yrs. last 77	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi		Year)	9. Birthp Court New Y	place (State or Foreign ork
	nyland how		Usual Residence of Decedent  10a. State 10b. County		10c. City, To						1	0d. Inside City Limits
	the Ma	Funeral Director	Maryland N/A  10e. Street and Number		В	altim	Ore 10f. Zip Code	. <u>.</u>		0g. Citize	n of What Coun	1 √ Yes 2 No
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980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If itam 27 is marked other than "natural", or itams 23a or 28a-f show any injury or other traumatic avent, Its Medical Examinar must be notified at ance.	by Fune	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced	12. Was Deceden Armed Forces 1 TYPes 2 If Yes, Give Year or Dates:	™ Korean	1	Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2 ☑ No	spanic Origin? n, Mexican, Pu Specify:	(Specify Yes or No- erto Rican, etc.)		. Race - Americ Black, White, pec <i>ify:</i> White	etc.
Maryland 21215-0036	hin 72 hi in "natu Medical	Completed by	15. Decedent's Ed (Specify only highest grad			Sa. Deced (Give life. I	dent's Usual Occupa kind of work done o DO NOT use retired	ition Juring most of w	rorking	16b. Kind	of Business/Ind	dustry
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21	Pnysician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of immediate Cause (Final disease or condition	lications that cause ne cause on each	od the death. D	o not ent	er the mode of dying	g, such as cardi		est,		Approximate Interval Between Onset and Death
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3760,	ficate be executed g physician and as the burial-transit	cal	resulting in death) Last	c. Due to (or as	s a consequenc	e of):						
P.O. Box 68	The law requires that the death certifica ate has been signed by the attending ph page 2 should be delached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		e of pregnancy 2  Fetal dea at time of death		Ectopic pregnancy Other (specify)			236	d. Date of delive Month	ory Day Year
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Vita	ysician: Thi is certificate director, pag	o Be	25. Was case referred to medical examiner? 1 □ Yes 2√2 No	Hospital: 1 □ Inpat	ient 2 ER/0	Outnation	t 3□ DOA Othe	The second second	eath <i>(Check only on</i> Home 5□Reside		Other (Specifi	4)
Division of	ling Ph	Certification; T	27. Manner of Death  1 A Natural 5 Pending 2 Accident investigation	28a. Date of Inj (Month, Da	ury 28b	. Time of Injury	28c. Injury Work	at	28d. Describe ho			0
Divis	il or Attandi after death. I Director: A d in by the fu	ertific	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Ir building, e	ijury - At home, tc. <i>(Specify)</i>	farm, str	eet, factory, office		28f. Location (Si City or Town		Number or Rura	l Route Number,
	To the Hospital or At within 24 hours after or To the Funaral Directompletely filled in by	Medical C	29a. Certifier 1 Certifying Phy 2 Medical Exam	sician: To the besi ner: On the basis and manner s	of examination a	lge, death and/or inv	occurred at the time restigation, in my op	e, date and pla inion, death oc	ce, and due to the c curred at the time, d	ause(s) ar ate and pl	nd manner as st ace, and due to	ated. the cause(s)
	To the within 2. To the Complet	W	29b. Signature and Little 1 satisfier	loen			29c. License				signed (Month, I	
L.	5+1		30. Name and address of person who c	ompleted cause of ADI. N	death (Item 23a	a) (Type,	Print)	LEK	Dr.	Tou	SONI	TD Zizcy
	Sta Registr		31. Date filed (Month, Day, Year)  JUL 0 6	2007 32. Remist	rar's Signature	4 /	carle					/

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Year KREINER 9-10 PM 2000 GERTRUDE JUNE 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Name (If not institution, give street and number) Baltimore County GENESIS ELDERCARE: MULTIMEDICAL CENTER Towson If Under 24 Hrs. If Under 1 Year Months Days 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 M 2 TXF Hours July 28, 1923 Maryland 218-18-1932 84 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b County 1 ☐ Yes 2 No Baltimore County Towson Maryland 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code 21204 USA 7700 York Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 12. Wes Decedent Ever in U,S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Hospital Switchboard Operator 10th 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Katherine Tully Sternagle William 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Louis E. Kreiner, Jr. (Son) 2334 Dale Drive, Falls Church, Virginia 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Most Holy Redeemer Cem. 7/3/2007 Baltimore, Maryland 21. Signature of Furnital Server Licensen 22. Name and Address of Fedility MITCHELL-WIEDEFELD FUNERAL HOME, INC. 6500 York Road, Baltimore, Maryland 21212 Approximate Interval Between Onset and Death 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. e. CONGESTIVE HEART FAILURE Due to (or as a consequence of): b. CEREBRO UASCULAR ACCIDENT Due to (or as a consequence of): Immediate Cause (Final disease or condition resulting in death) 4000 DENENTIA Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Miknown

Physician /Medical Examiner

parmit. Peges 1 and 2 should be filk Department of Health and Mental Hy important: If them 27 te marked other eny Injury or other treumatic event

Physician

Examiner

Funeral

Director

item 27 is marked other than "neturel", or itema 23a or 28a-f show other treumatic event, the Madical Examiner must be notified at

altimore, Maryland 21215-0020

/Medical

Director

Funeral

Š

Completed

Be

Examir Physician/Medical

Division of Vital Records, P.O. Box 68760,

or Attending Physicien: after death. Director: After this certifice

To the Hospital of within 24 hours a To the Funeral D

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

					24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
					12 Yes EENC	1 ☐ Yes 2 🗹 No
25. Was case referred to medical			26	Place of Death	(Check only one)	
examiner?	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	DOA Other:	Nursing Hor	me 5□ Residence 6 □Ot	her (Specify)
27. Manner of Death  1 Natural 5 Pending 2 Accident investigation		28b. Time of Injury	28c. Injury at Work? 1 ☐ Yes	2 □ No	28d. Describe how injury occu	rred
27. Manner of Death  1	28e. Place of Injury - At h building, etc. (Specia	ome, farm, street, fa	actory, office	2	28f. Location (Street and Num City or Town, State)	ber or Rurel Route Number,

(Check only one)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Shawn Mara Coppa 9650 Santrejo Rd Stute 110, Columbic

Date filed (Month, Day, Year) 2007 | 32 Registrar's Signature 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

0

32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene

		1 - For State Registrar	State of Ivia	arylaric		tificate of E			Reg. No.	2007	217	23
Physici	ian	1. Decedent's Name (First, Middle, La	ast)		T _ L	L		2. Date of Deadline July		200 <sup>7</sup> ear	3. Time of De 2:10A.	eath
/Medi	_	Edward			Let	teri						IVI
Examir	ner	4a. Facility Name (If not institution, gir Montgomery Villa				4b. City, Town, or Rockvi		n		County of Deatl Contgome		
<u></u>	25-			e (In yrs. la	ast birthday)	If Under 1 Year	If Under 24 Hrs	8. Date of Birt	th	9. Birth	nplace (State or F	Foreign
Funeral Director			<sup>1</sup> X M 2□ F 94		Yrs.	Months Days	Hours Min.	Oct. 2,			intry) 1 y	
land ow		10a. State 10b. County		10c. City	, Town or Lo	cation					10d. Inside City	Limits
Many Ffsh fied	to	MD Montgome	ery	Gait	hersb	urg					1 □ Yes 2	<b>X</b> □No
h the or 282 e noti	irec	10e. Street and Number				10f. Zip Code			10g. Citiz	zen of What Co	untry?	
th wil	Funeral Director	24528 Hanson Roa	ad				882		USA			
r dea	nuel	11. Marital Status	12. Was Decedent I Armed Forces?		3. 13.	Was Decedent of His f Yes, specify Cubar	spanic Origin? (S n, Mexican, Puer	Specify Yes or No to Rican, etc.)	- 1	<ol> <li>Race - Amer</li> <li>Black, White</li> </ol>		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Fi	1 ☐ Never Married 2 🕅 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 X N If Yes, Give Year or Dates:	NO WWI		1∐Yes 2 <b>X</b> ∏No	Specify:			Specify: Wh	ite	
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vithin ne. han "	ם	Elementary/Secondary (0-12)	College (1-4or 5	+)		00 NOT use retired) /Bricklay			C	onstruc	tion	
iled v Hygie ther t	ပိ	17. Father's Name (First, Middle, Las	:t)		Habon			me (First, Middle,			e ron	
d be i	Be C	Panfilo Letteri	7				Anie	lina Tro	ia	,		
Shoul nd Me mark mati	2	19a. Informant's Name/Relationship	(Type. Print)		19b. Mailir	ng Address (Street a				r Town, State, Ž	ip Code)	
nd 2		Yvonne Pelaia	(Daughter)		245	28 Hanson	Rd. Ga	aithersb	urg,	MD 20	882	
item item othe		20a. Method of Disposition	,	20b. Pl	ace of Dispo	sition (Name of matory or other place	9)	Date	20c. Loc	cation - City or	Town, State	
Page nent c		1 ABurial 2 ☐ Cremation 3 [ 4 ☐ Donation 5 ☐ Other (Spec				's Cemete	10	/07	Ch:	ippewa '	Twp., PA	
rmit. porta y inju		21. Signature o Funeral Service Lice	ensee	2	22	2. Name and Addres						
89 E 8 9	U ()	Juen	Duel	<u>LQ</u>				nue Bear		Falls,	PA 15010	1
		23a. Part1. Enter the disease, or con shock, or heart failure. List only	mplications that caused y one cause on each lir	the death ne.	. Do not ent	er the mode of dying	g, such as cardia	ic or respiratory a	rrest,		Approximate Interval Betwee Onset and De	een eath
Physician		Immediate fause (Final disease or condition resulting in death)				134 310	RIF	ALLOR	<b>E</b>			
/Medical Examiner		resulting in death)	Due to (or as	a consequ	ence of):							
	ja l	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	a consequ	ence of):							
uted J ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events										
tificate be executed g physician and as the burial-transit	Exa	resulting in death) Last	Due to (or as	a consequ	ence of):							
te be ysicia ne bur	edical		<b>d</b>									
# D &		IF FEMALE:										
The law requires that the death cer ate has been signed by the attendin page 2 should be detached for use	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal	death 3 [	Ectopic pregnancy Other (specify)			2	23d. Date <i>o</i> f del Month	very Day Ye	ar
s that ined t	by Pl	Part II. Other significant conditions	contributing to death be	ut not resu	Iting in the u	nderlying cause give	n in Part I.	23e. Did t	obacco u	se contribute to	the cause of dea	ath?
w requires to been signed should be								1 🗆	Yes 2	No 3□Pr	obabiy 4 □Un	ıknown
law re as be 2 sho	Completed							24a. Was			topsy findings av	
sician: The law certificate has birector, page 2 s	Com								rmed?	death? 1 ☐ Yes	127	
clan: ertific ector,	Be (	25. Was case referred to medical examiner?	la sal			Z I au		eath (Check only o	one)			
_ હું હ	၉	1 ☐ Yes 2 No	Hospital:		ER/Outpatier		Nursing	Home 5 ☐ Resi			cify)	
Jing F	ion:	27. Manner of Death  1 ✓ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da		28b. Time o Injury	Work	rat :? /es 2 ∐ No	28d. Describe	now injur	y occurred		
death ctor: / the	icat	2 Accident investigation 3 Suicide 6 Could not	be as Place of init	urv - At ho	me, farm, st	reet, factory, office	les Z INO	28f. Location (	Street and	d Number or Ru	ıral Route Numbe	er.
after Dire	Certification:	4 ☐ Homicide determined	building, et	c. (Specify	)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or To				,
To the Hospital or Attending PP within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Medical C		Physician: To the best aminer: On the basis o and manner sta	f examinat								
To the vithin To the compl	Me	29b. Signature and title of certifier		A	Λ	29c. License		8.5		e signed (Mont	h, Day, Year)	
			~ /M		/		0512	00	-			
6	1	30. Name and address of person who	o completed cause of d		,	Print)						
		Anushiravan	Dadgar, MD	971	5 Med	ical Cent	er Dr.	#201 Ro	ockvi	lle, MI	)	

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene (1)

	Certificate of Death Reg. No.
Physician	1. Decedent's Name (First, Middle, Last)  2. Date of Deeth Month Day Year 3. Time of Death
/Medical Examiner	4a Facility Name (If not institution, give street end number)  4b. City, Town, or Location of Deeth  4c. County of Deeth
Funeral Director	15 HICKORY COURT  5. Social Security Number 215-26-3366  1 M 2 F 7. Age (In yrs. lest birthday) 76 Yrs.  WESTMINSTER CARROLL  8. Date of Birth (Month, Day, Year) 12/27/1930  9. Birthplace (State or Foreign Months) 12/27/1930  MARYLAND
ahow at at	Usual Residence of Decedent  10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limit  MD CARROLL. WESTMINSTER 1□ Yes 2XIN
ith the Maryle or 28s-f shov or notfried at	MD CARROLL WESTMINSTER  1 □ Yes 2 ¾ N  10e. Street end Number  10f. Zip Code  10g. Citizen of What Country?
5-0036 72 hours after deeth with the Maryland natural; or items 23s or 28s-f show dical Examiner must be notified at eted by Funeral Director	3 □ Widowed 4 □ Divorced   If Yes, Give KOREAN   1 □ Yes 2X No Specify:   Specify: WHITE
d within plene.	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) 1 2  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  HEAVY EQUIPMENT OPERATOR CONSTRUCTION
re, Maryland 2 stand 2 should be filed the filed the Trie merked other other traumatic event.	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)
Mary	19a. Informent's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  ORPHA J. LAUER - WIFE  15 HICKORY CT., WESTMINSTER, MD 21157
Baltimore, semit. Pages 1 ar Sepertment of Hea moortant: if Item iny Injury or othe ance.	20a. Method of Disposition   20b. Place of Disposition (Neme of cemetery, cremetory or other place)   20c. Location - City or Town, State   20c.
Baltimo permit. Pages Depertment of Important: if I any Injury or and	21. Signature of Funeral Service Licensee  22. Name and Address of Fecility FLETCHER FUNERAL HOME, P. 254 E. MAIN ST., WESTMINSTER, MD 21157
Physician /Medical Examiner	23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or useft failure. List only one cause on each line.  Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death)  e. ATHERO SCLEROTIC CORONIER / IFEART YEARS Due to (or as a consequence of):
Box 68760, which continues to executed attending physician and for use as the burial-transit stan/Medical Examiner	
O. Box ne death cer the attendir hed for use	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23b. Did tobacco use contribute to the cause of death
cords, P.O. Box requires that the death cert result by the attendinhould be detached for use eted by Physiclan/M	PRIERIOSCHEROTIC PERIPHERAL VASCULAR  DISEASE  240 Was as subsequently 24b Was as subsequently 4 Unknown and 15 Mars as subsequently 24b Was as subsequently 15 Mars as subseq
Rec	24a. Wes an autopsy performed?  24b. Were autopsy findings available prior to completion of ceuse of death?  1 Yes 2 No 1 Yes 2 No
isn:	25. Was case referred to medical aximiner? 26. Place of Death (Check only one)
Division of that or Attending P its after death. The Director: After the ided in by the funere Certification:	3 ☐ Suicide 4 ☐ Homicide  Could not be determined  City or Town, State)  Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Route Number, City or Town, State)
the Hospi in 24 hou the Funer pletely fill ledical	29a. Certifier  (Check only one)  Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner steted.
To the common common	Vennet of francis ms DO1663 17/5/09
541	30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print)  VINCENT J. Flores JR  WESTMINSTER VID 21150
State Registrar	31. Date filed (Month, Day, Year)  32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** July 4, 2007 5:25 P. M Subbulakshmiammal Lakshmiammal /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Montgomery 17220 Larosa Drive Derwood If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 🛣 F 215-59-9834 76 Director Sept. 28. 1930 India Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 23a or 28a-f show 10d. Inside City Limits the Medical Examiner must be notified at 1 ☐ Yes 2X No Directo Maryland Montgomery Derwood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17220 Larosa Drive Funeral 20855 United States death 'natural', or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner once. 1 ☐ Yes 2 ⅓ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify <u>Ş</u> Specify: 3 Widowed 4 Divorced Asian Indian Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sankaranarayanan Subbulakshmiammal 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Krishnan Ramesh / Son 17220 Larosa Drive, Derwood, Maryland 20855 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) July 6, 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Montgomery Crematorium, Inc. 2007 Bethesda, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethsda-Chevy Chase, Inc. 21. Signature of Funeral Service Lic risee M00896 7557 Wisconsin Ave., Bethesda, MD 20814-3501 23a. Part1. Enter the dise shock, or heart failur complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Congestive Heart Failure Days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner End Stage Renal Disease Years Sequentially list conditions Due to (or as a consequence of) ause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed attending physician and for use as the burial-tra Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) signed by the a d be detached f Division or Vital Records, P.O. 1 ☐ Yes 2 X No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? ate has page 2 s 24a. Was an 1□ Yes 2 X No 2□ No 1 TYes or Attending Physician; director, 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA Other: 4 Nursing Home 5 🛛 Residence 6 Other (Specify) 1 ☐ Yes 2[5t No 28a. Date of Injury funeral 27 Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1X XNatural 5 ☐ Pending investigation ours after death.

neral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a

To the Funeral I

completely filled To the Hospital 1 deterifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D32332 July 5, 2007 0. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suresh K. Gupta, M.D., 9801 Georgia Ave. #220, Silver Spring, Maryland 20902 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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		I- For State Registrar			Certif	icate of	Death				R	eg. No.			
Physicia ledical Examin	1/	Decedent's Name (First, Middl	·	Carl	Stan	ley	Lack:	L, J	r.		Date of Dea Month July 2, 20	ath Day	Year		me of Death 105 hrs
		4a. Facility Name (if not institutio Franklin Square Hosp		nd number)				n, or L	ocation of			4c.	County o	f Death e County	
Funeral Director		5. Social Security Number 217-06-7663	6. Sex		e (In yrs. last	birthday) Yrs.	If Under Months	Year Days	If Under	24Hrs. Min.	8. Date of Bi June	•	·	9. Birthplac Foreign Country)	e (State or Mary land
any	ŀ	Usual Residence of Decedent  10a. State 10b. County				wn or Locatio	n			1					Inside City Limits
*	ا يو	Maryland Bal	ltimore						svill	Le	<u></u>	10- 04-	f \\/\	1 [ at Country?	Yes 2 X No
ith the Maryland 23a or 28a-f sho notified at once.	Ö	8057 Philade	elphia I	Road			10f. Zip C	123	7			Ü		states	i
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she tranmatic event, the Medical Examiner must be notified at once	Funeral	11. Marital Status  1 XNever Married 2 Married 2	arried Arm	ed Forces?	Ever in U.S.		Decedent	of Hisp			cify Yes or No ican, etc.)			- American Ir	ndian, Black,
urş afteri tural", o	<u>a</u>	3 Widowed 4 Div 15. Decedent's Education (Spe	orced If Yes, Giv	e Year		Sa. Decedent		cupatio	n (Give kir				Specify: nd of Bus	iness/Indust	White
21215-0036 Id be filed within 72 hours after when I Hygiene. narked other than "natural"; event, the Medical Examiner.	Completed	Elementary/Secondary (0-12)	Colle	ge (1-4 or	5+)	during mo					d)		T v errors	. How	Co
15-0036 filed within 7 ll Hygiene. ed other than t, the Medica		11 Years 17. Father's Name (First, Middle,				Fenc	e ins	18	3.Mother's	Name (I	First, Middle,	Maiden S	Surname)	ic ren	ce Co.
D 2121 should be find Mental I is marked	To Be	Carl S. Lac 19a. Informant's Name/Relations				19b. Mailing				er or Ru		mber, Çit	y or Towr		
imore, MD 2 Pages 1 and 2 shou' nent of Health and N inent: If item 22,	ŀ	Margaret Shi 20a. Method of Disposition  1 Burial 2 X Cremation			20b. Plac	296 ce of Disposit matory or othe	ion (Name				ad Du Date	ndall 20c. L	k , Mi ocation -	D 212 City or Town	22 , State
		4 Donation 5 Other Sp. 21. Signature of Funeral Service	pecify:	var ir diri di		ltop S	ervic			7/9	9/2007	T	owso	n, Mar	yland
Balt Permit Depart Import injury	3	23a. Part I. Enter the disease, or	complications t	hat caused	the death. Do	D not enter the	uda-R 7922 mode of	uck Wise	Fune Ave	ral Trdiac or r	Home undall espiratory ar	of Di	unda iry ck. or hea	lk In	222 proximate Interval
/Medical raminer	ž.	failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	on each line. a. Multiple	Gunsho	ot Wounds										etween Onset and Death
	اي	Sequentially list conditions,	b		equence of):										
	Examiner	if any, leading to immediate cause. Enter Undarrying Cause (Disease or injury that initiated events resulting in death). Last	С.		equence of):										
	- 1	UNPENDED UNPENDED	d. V AMENIC	nen											
760, ficate be execut g physician and s the burial - tra	5 k	IF FEMALE: 23b. Was decedent pregnant in the	23c. If	perInf yes, outcor live birth	, G869, ne of pregnar	ncy		3	Ectopic p				. Date of	delivery Day	Year
Box 68 death certi the attending	Physiciar	past 12 months?  1 Yes 2 No 9 Uni	4F		time of death		er (Specif		Ectopic p	pregnam			WOTH	Day	real
, P.O. Box 68 res that the death certific signed by the attending be detached for use as	by Ph	Part II. Other significant condit			h but not resu	Ilting in the ur	iderlying c	ause giv	ven in Part	t I.				-	ause of death?
ords, I	Completed		·								24a. Was	an	24b. V	Vere autopsy	findings available etion of cause of
tal Reccinan: The lav		25. Was case referred to medica						Diago	of Death (C	Chark or	1 🗸 Yes	ormed?		eath? ✔ Yes	2 No
/ital	o Be	examiner?	Hospital: 1	Inpatie	ent 2 🗸 EF	R/Outpatient		To	thor:		Home 5	Resider	nce 6	Other:	
ling Ph After 1 funeral	- 1	1 Yes 2 No  27. Manner of Death  1 Natural 5 Pend	ding Jul	Date of Inju Month, Day, Y 2, 2007	Jry 28	8b. Time of In 046 hrs	jury 28		at Work?	ls.	8d. Describe ubject wa		ry occurre	ed	
Division pital or Attent ours after death neral Director: filled in by the	Certification:	3 Suicide 6 Coul	d not be		jury - At home		, factory, c	ffice bu	ilding, etc.		or Town.	State)		er or Rural Rosedale, Md.	oute Number, City
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	20a Cortifier	hysician: To the	asis of exa											se(s)
F	₽	29b. Signature and title of certifie		ner stated.	,	<del></del>		icense	number				3, 200	d (Month, D	oay, Year)
6	-	30. Name and address of person Jack Titus MD. Dep	who completed outy Chief M		`	3a) 111 Peni	Street	Balti	more. M	MD 212	01				
Sta Registr		31. Date filed (Month, Day, Year)			r's Signature	-	24/2								
DHMH 17 Rev 1/200	_	- JULV	0 5001	J. Signer	163 A S.	ORIGINAL					OCME				

			Please	State of Manua						egible.		
			For State	State of Maryla		ariment of F rtificate of		,	•	000=	75 H *	7 0 7
	The Real		Registrar  1. Decedent's Name (First, Middle, La	ast)		runcate or	Death	2. Date of De	Reg. No.	<u> </u>	3. Time of D	Death
i.	Physicia /Medic		JAMES	,	LINI	DENMUTH		JUNE	28,	, 2007	7:45	
	Examin		4a. Facility Name (If not institution, gi	ve street and number)		4b. City, Town, c	or Location of Deatl	1	4c. C	ounty of Death		
	K		FOREST HILL HEAL				EST HILL			HARI		
i	Funeral Director			Sex   7. Age (In yrs 1 ▼ M 2 □ F   84	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	ıy, Year)		olace (State or ntry) sylvan	
	land ow at		10a. State 10b. County	10c. C	ity, Town or Lo	ocation				1	I0d. Inside City	Limits
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	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citize	en of What Cour	ntry?	
	ath w	ral	600 Squire Lane				21014			USA		
	items ner n	Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in I Armed Forces?	U.S. 13.	Was Decedent of H If Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puer	pecify Yes or No o Rican, etc.)	- 12	<ol> <li>Race - Americ Black, White,</li> </ol>		
336	urs af	by	3 ☐ Widowed 4 ☐ Divorced	1 TYes 2 □ No If Yes, Give Year or Dates: 1 / 7	2-46	1 ☐ Yes 2 🎇 No	Specify:		5	Specify: whi	lte	
5-0036	72 hou	sted	15. Decedent's E	ducation	16a. Dece	dent's Usual Occup	pation	un	16b. Kind	d of Business/In	dustry	unk
2	ithin ne.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done DO NOT use retire	d)	nng				
121	be filed within 72 hours after death with the Maryland ntal Hygiene. A other than "natural", or items 23a or 23a-f show event, the Medical Examiner must be notified at	S	12 17. Father's Name (First, Middle, Las	<u>5+</u>			18. Mother's Nar	ne (First, Middle	. Maiden S	urname)		
au	0 = 0 5	To Be	Frederic Calvin	*				ha Bell		,		
Maryland	s 1 and 2 should be if Health and Menta item 27 is marked other traumatic ev	۲	19a. Informant's Name/Relationship	(Type. Print)	19b. Maili	ng Address (Street	and Number or Ru	ıral Route Numb	er, City or	Town, State, Zir.	Code)	
	t and 2 Health a tem 27 is		Miriam Lindenmuth		600	Squire La	ane #1D F	el Air.	MD 2	1014		
ore			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 [	☐Removal from State	Place of Dispo cemetery, cre-	osition (Name of matory or other pla	ce)	Date	20c. Loca	ation - City or To	own, State	
Baltimore,	it. Pa irtmen irtant: njury	-	4 ☑ Donation 5 ☐ Other (Spec.	/ /	2	2. Name and Addre	ess of Engility					
Ba	permit. Page Department of Important: If any injury or once.		monald s	Carle_	or St Ba	tate Anat altimore,	omy Boar MD 2120	)1		imore S	Street	
			23a. Rart1. Enter the disease, or con shock, or heart failure. List only	one cause on each line.	1 -		ng, such as cardiad	or respiratory a	rrest,		Approximate Interval Betwo Onset and De	een
	Physician /Medical		Immediale Cause (Final disease or condition resulting in death)	a Pancrea		incer					Llyl	W
	Examiner			tue to (or as a conse	equence of):							
à,		ner	Sequentially list conditions, if any, leading to immediate cause. Entire fundering Cause (Disease or injury	b. Due to (or as a conse	quence of):							
	eath certificate be executed attending physician and for use as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c								
60,	be exician a	al E	Toolking in doubly Educ	Due to (or as a conse	quence or):							
289	certificate iding physise as the	edic		d								
ROX	n certii anding use a	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pregr					23	3d. Date of delive	ery	
	0 0	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown		⊒Ectopic pregnanc ⊒ Other <i>(specify)</i> _	y 			Month	Day Ye	ear
J.	at the ded by the a	Phys	9 Unknown		andian in the co		on in Dani I	age Did A				-450
Vital Records,	The law requires that the te has been signed by the rage 2 should be detache	þ	Part II. Other significant conditions	contributing to death but not re	sulting in the u	indenying cause giv	en in Part I.			e contribute to tl No 3∏ Prob		
Ö	w req	Completed						24a. Was	an	24b. Were auto	nosy findings av	vailable
Ť	sician: The law certificate has b irector, page 2 s	dwo						auto perfo	psy ormed? 2 No	prior to co death? 1 ☐ Yes	mpletion of cau	use of
<u> </u>		Be C	25. Was case referred to medical examiner?				26. Place of Dea	1  Yes ath (Check only o		T Tes	2   140	
or	Physic this ce al direc	일	1 Tes 21 No	Hospital: 1 ☐ Inpatient 2	· · · · · · · · · · · · · · · · · · ·		4 Nursing F	lome 5 ☐ Resi	dence 6	□Other (Specil	fy)	
	ig ter	ion:	27. Manner of Peath  1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wo	ryat rk?  Yes 2∐No	28d. Describe	how injury	occurred		
DIVISION	Atten r deatl ector: by the	fical	3 Suicide 6 Could not b	28e. Place of injury - At I	home, farm, sti		1.00 2			Number or Rura	al Route Numb	er,
É	tal or safter al Dire	Certification:	4 ☐ Homicide determined	building, etc. (Spec	city)			City or To	wn, State)			
	To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Al completely filled in by the fu	Medical (	29a. Certifier (Check only one) 1 Certifying P	hysician: To the best of my kr miner: On the basis of examir	nowledge, deat nation and/or ir	h occurred at the ti	ime, date and place opinion, death occi	e, and due to the urred at the time,	cause(s) a	nd manner as s place, and due t	tated. o the cause(s)	
	o the	Med	29b. Signature and title of certifier	and manner stated.		29c. Licens	se number		29d. Date	signed (Month,	Day, Year)	
	⊢s⊢ő			e tun	~0		3186		June	29.2	2007	
7			30. Name and address of person who	completed cause of death (Ite	em 23a) (Type,					, -, -, -,		
				Tinney mo	Le15	w. mcP	hail Ro	d Bel	AN	MD.	21014	
I	Sta Registr		31. Date filed (Month, Day, Year)  JUL 0 6 200	completed cause of death (Ite	lature	2						
			V V Inq	9 100	6 /							

			For	State of N	/larylan		artment of I		Mental H	giene		01-	120
			1 - State Registrar			Ce	rtificate of	Death		Reg. No.	LUUI	411	40
it.	Physici	an	Decedent's Name (First, Mid	-					2. Date of D Month	Day	Year	3. Time of	
	/Medic		Dona  4a. Facility Name (If not institut.	Ritchie	ur)	Maz	zara	or Location of De	July 2		Oounty of Dea	Unk	M
	Examin	er	20245 Shipley		")			antown	auı		ntgome		
	Funeral		5. Social Security Number		Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 H	rs. 8. Date of B	irth	9. Bir	thplace (State o	or Foreign
	Director		116-36-7419	1 □ M 2 <b>X</b> F	62	Yrs.	Months Days	Hours Mi	Jun 20	ay, Year) 194		NY	
	pu ,		Usual Residence of Decedent  10a. State 10b. Coun		100 Cit	y, Town or Lo	cotion					10d. Inside Ci	the Limite
	shov shov	5	Toa. State Tob. Coun	ly								1  Yes	•
	the M	Director	MD Mon  10e. Street and Number	tgomery	Ge	ermant	OWN 10f. Zip Code			10g Citiz	en of What Co		
	with Sa or t be r	Ē	20245 Shipley	Terrace			2087	7 /1		US		Juntity .	
	ms 2;	Funeral	11. Marital Status	12. Was Deceder		S. 13.	Was Decedent of H		(Specify Yes or N		4. Race - Ame		
9	after or ite πine	Ful	1 ☐ Never Married 2 ☐ Ma	Armed Forces arried 1 X Yes 2 I If Yes, Give			ir Yes, specity Cub 1 □ Yes 2 2 1 No		erto Hican, etc.)		Black, White Specify: W.		
93	ours iral",	d by	3 ☐ Widowed 4 🖾 Divorce	ed Year or Dates			TES ZEANO	эреспу.			Specify: W	11116	
21215-0036	72 h "natu dical	Completed	15. Decede (Specify only high	ent's Education nest grade completed)		16a. Dece (Give	dent's Usual Occu kind of work done DO NOT use retire	pation during most of w	vorking	16b. Kin	id of Business	/Industry	
12	within sne. than	m d	Elementary/Secondary (0-12)	College (1-4o	r 5+)		nistrativ			Mo	ancino		
d 2	filed Hygir Sther ent, tl	ပိ	17. Father's Name (First, Middl			Aumi	IISLIALIV	T	lame (First, Middl		gazine Surname)		
an	ld be lental ked c	To Be	Donald S. Ri	tchie				Evely	n C. Cor	sa			
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at ance.	-	19a. Informant's Name/Relation	nship (Type. Print)		19b. Mailir	ng Address (Street	t and Number or	Rural Route Num	ber, City or	Town, State,	Zip Code)	
2	and 2 ealth a n 27 ls		David Mazzara	/Son		1 Hu	stwood I	Orive, S	hirley,	NY 1	1967		
Baltimore,	of He fitem		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 Removed from State	20b. F	lace of Dispo emetery, cre	sition (Name of matory or other pla Lnt Rural	ace)	Date	20c. Loc	cation - City or	Town, State	
Ĕ	Pages ment of I ant: If ite lury or o		4 Donation 5 Other			emeter	J	/-	7-07	Nort	hport,	NY	
3alt	permit. Departm Importa any Inju		21. Signature of Funeral Service	e Licensee	70		2. Name and Addre						L Home
	0 D = # 0	-/	23a Part1 Enter the disease,	Mina	2		Laurel				Y 117	Approximat	
NEW N	Physician /Medical Examiner points in prival-transit per prival-transi	ical Examiner	Immediation Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Liner underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Metas Due to (or a  b. Due to (or a  c. Due to (or a	as a conseq as a conseq	uence of): uence of):	ctal Can	cer					
Division or Vital Records, P.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certificate i within 24 hours after death.  within 24 hours after death.  completely filled in by the funeral director, page 2 should be detached for use as the temperal or the funeral director.	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown	23c. If yes, outcom 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 ☐ Feta at time of d	Ideath 3[	Ectopic pregnanc Other (specify)	cy	-	2	3d. Date of de Month		Year
rds, P	quires tha in signed l	þ	Part II. Other significant conditions Cardiomyopat	_	but not res	ulting in the u	nderlying cause gi	ven in Part I.				o the cause of c robably 4 □l	
Reco	: The law re cate has bee page 2 sho	Completed							24a. Wa aut per 1∐ Yes	opsy form <u>e</u> d?	prior to death?	utopsy findings completion of c	available ause of
Ħ	iclan: Th certificate ector, pag	Be C	25. Was case referred to medic examiner?	al				26. Place of D	eath (Check only			20110	
<u>&gt;</u>	ding Physiclan:  After this certific funeral director,	To E	1 ☐ Yes 2 No			ER/Outpatier	" OLI DOA		Home 5K Re	sidence 6	☐Other (Spe	ecify)	
ū	ing P	ü	27. Manner of Death 1 X Natural 5 □ Pend	iiiig	njury Day Year)	28b. Time o Injury	Wo		28d. Describe	how injury	occurred		
Sio	ttend leath. stor: /	cati	2 Accident inves 3 Suicide 6 Coul	d not be	miume At he	ma farm ot		]Yes 2□No	201 1	(0)		- (B-1) N	
<u>≥</u>	or A	Certification:	4 Homicide dete	rmined 26e. Place of the building,	etc. (Specif	y)	eet, factory, office		City or T	(Street and own, State)	Number or H	ural Route Nurr	iber,
_	To the Hospital or Attenwithin 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 X Certify	/ing Physician: To the bes	st of my kno	wledge, deat	h occurred at the t	ime, date and pla	ace, and due to th	e cause(s)	and manner a	s stated.	
	le Ho 24 h e Fu	Medical	(Check only 2 ☐ <b>Medic</b> one)	al Examiner: On the basis and manner:	of examina	ition and/or in	vestigation, in my	opinion, death or	ccurred at the time	e, date and	place, and du	e to the cause(s	3)
	To the within 2 To the Complet	Ň	29b. Signature and title of certif	ier			29c, Licens	se number		29d. Date	signed (Mon	th, Day, Year)	
			Chilie	Eleponel	_		D424	52		July	3, 200	)7	
	0		30. Name and address of person										
	8		Chitra Rajago		l Pri	nce Ph	psu	#327,	Olney, M	D 20	832		
	Sta Registr		31. Date filed (Month, Day Yea	10 6 200 32. Head	trar's Signa	ilure /s	1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 5, 2007 7:30 A M July Esther E. Meise /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel Odenton 558 Edwards Drive 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Oct 23, 1919 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1 □ M 2 🕅 F Maryland Director 87 215-01-1693 Usual Residence of Decedent Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State ral", or items 23a or 28a-f show Examiner must be notified at to Yes 2 No Funeral Director Odenton Maryland Anne Arundel the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with enen of Health and Mental Hygiene. Interest if item 27 is marked other than "natural", or items 23a or runy or other traumatic event, the Medical Examiner must be a runy or other traumatic event, the Medical Examiner must be a United States 21113 558 Edwards Drive 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: þ 3 ☑ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 9th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ruth Workinger Lauf 2 Douglas A. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 558 Edwards Drive Odenton, Maryland 21113 Sharon E. Ascherl/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Department of Important: If it any injury or conce. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State West Arundel Crematory 7/6/2007 4 □ Donation 5 □ Other (Specify) Odenton, Maryland 22. Name and Address of Facility
Donaldson Funeral Home & Crematory, P.A. 21. Sign Tyre of Funeral Service Lisensee Thomas 1411 Annapolis Road Odenton, Maryland 21113 atmar 23a. Park) Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 3 years Emphysema /Medical Due to (or as a consequence of): Examiner Convestive Heart Failure 3 years Sequentially list conditions, if any, hading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed the burial-tran and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 TYes 2√ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s 2 No 2 ₽ No director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☑ No Certification: To this 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 X Natural Injury

Division or Vital Records, P.O. Box 68760, or Attending Physician: funeral After death. after death the filled in by within 24 hours a

To the Funeral I

28a. Date of Injury (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only

State

Medical

X

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1667 Crofton Center, Suite 1, Crofton, MD21114 Crofton Medical Group Dr. Nusairee

29c. License number

D0040519

29d. Date signed (Month, Day, Year)

July 6, 2007

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

32. Registrar's Signature MARIAN.

Registrar

## Physician /Medical **Examiner Funeral** Director with the Maryland . 28a-f shov notified at Director ms 23a or must be r filed within 72 hours after death within Hygiene. Funeral ural", or Items 2 Baltimore, Maryland 21215-0036 þ Completed Be Pages 1 and 2 should be nent of Health and Mental ဂ္ S If item 27 or other t

Physician /Medical **Examiner** 

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The law requires that the death certificate be executed attending physiclan and for use as the burial-trar

Division or Vital Records, P.O. Box 68760,

within 2.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year 5:25 PM Carolyn McCrea une 2007 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number HOSPITOL Imber 6. Se Baltimore Baltimore N/A If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days 1 □ M 2 □ € 213-62-6057 Aug 1, 1954 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Y**X**S 2 ☐ No Baltimore N/A Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4226 Pimlico Road 21215 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ New Specify: Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) HSBC Co. Operations Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lillie Roberson Sinkler Roberson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4226 Pimlico Road Baltimore, Maryland 21215 Charlene Baldwin Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town. State 20a. Method of Disposition 1 ☐ Boxial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 07/03/07 Windsor Mill, Md. King Memorial Park 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Estep Brothers Funeral Service, P. A.
1300 Futaw Place Baltimore, Md 21217
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
smediate of critical field. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic breast Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examir Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ cell 4 Unknown carcinoma 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 X Natural 5 Pending investigation in 24 hours area the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RES-000 une 27 2007 1401 W BELVEDERE AVE, BALTIMORE MO 11215 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KATJA SINAL HOSPITAL OF BALTIMORE KISELJAK-VASSILIADES 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 06 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State	Maryland / Depa	artment of F			ene g. No. 2007	21731
1.6		2	Registrar  1. Decedent's Name (First, Middle, Last)				2. Date of Death Month		3. Time of Death
	Physicia /Medic		Jane Warrington Carr Monta		4h Oite Terre	al action of Dooth	July	5 200 4c. County of Deat	
	Examin	er	4a. Facility Name (If not institution, give street and numb Gilchrist Center	er)	Towson	or Location of Death		Baltimor	
	Funeral		5. Social Security Number 6. Sex 7.	. Age (In yrs. last birthday)		Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birt	thplace (State or Foreign buntry)
ča.	Director		213-30-2726   1LIM 2MF   Usual Residence of Decedent	74 Yrs.			ebruary	11,1933 N	Maryland
	aryland show d at	_	10a. State 10b. County	10c. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2XX No
	the Ma 28a-f	Director	Maryland Baltimore  10e. Street and Number	Kingsvill	_e 10f. Zip Code		10	g. Citizen of What Co	
	th with 23a or ist be	al Di	11721 Cedar Lane		21087			United St	ates
	er dear items	Funeral	11. Marital Status 12. Was Deceded Armed Force	ent Ever in U.S. 13.	Was Decedent of H If Yes, specify Cub	Hispanic Orlgin? (Spean, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
2-0020	urs aft al", or Exami	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 3 ☒ Widowed 4 ☐ Divorced Year or Date		1 ☐ Yes 2 💢 No	Specify:		Specify: Wh	nite
2	filed within 72 hours after death with the Maryland Hygiene. vther than "natural", or items 23a or 28a-f show snt, the Medical Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece (Give	edent's Usual Occup e kind of work done	pation during most of work d)	ing 1	6b. Kind of Business	/Industry
7 7	l within jene. r than the Me	omp	Elementary/Secondary (0-12) College (1-4 5+	lor 5+)		,		Baltimore	County
ana	e in o	Be C	17. Father's Name (First, Middle, Last)		,	18. Mother's Name	e (First, Middle, M	laiden Surname)	
Z	should tand Ment s marked umatic e	ပ္	Lewis Warrington Carr  19a. Informant's Name/Relationship (Type. Print)	19h Mail	ina Address (Street	1	adys Eite	City or Town, State, A	Zin Code)
M	and 2 sealth an n 27 is refer traus		Lisa Montanarelli/daughter			Ave., Suit		Brooklyn,	
ore,	es 1 a of Hea if item or othe		20a. Method of Disposition  1 X Burial 2 ☐ Cremation 3 ☐ Removal from St		osition (Name of ematory or other pla			Oc. Location - City or	
Saltimor	t. Pa tmer tant: tant:		4 Donation 5 Other (Specify)	Dulaney Va	alley Mem	GardJuly 1	.0,2007	imonium,	Maryland
מ	permit Depar Impor any ir once.		21. Signature of Funeral Service Licensee	Σ ΄	Mitche 6500	ell-Wiedei York-Rd.	eld Fune	eral Home, ore, MD 2	Inc. 1212
		95.	23a. P. M. Enter the disease, or complications that cause on each or ck, or heart failure. List only one cause on each	ised the death. Do not en	nter the mode of dyi	ng, such as cardiac	or respiratory arre	st,	Approximate Interval Between
	Physician //		Immediate Cause (Final disease or condition resulting in death)	blasting	multif	rine			Onset and Death
	Examiner		Die to (or	r as a consequence of):					
	p; it	iner	Sequentially list conditions, if you had you have a cause. Enter Underlying Cause (Disease or injury	r as a conse uence of):					
P	be executed ician and burial-transit	Examiner	that initiated events	r as a consequence of):			·		
2/00,	cate be executed ohysician and the burial-transit	dical E	d						
Ď	certifica nding phuse as th		IF FEMALE:						
200 200	w requires that the death certific been signed by the attending p should be detached for use as i	Physician/Me	in the past 12 months?		□Ectopic pregnanc	ey .		23d. Date of de Month	livery Day Year
	law requires that the death as been signed by the atter 2 should be detached for u	hysi	9 ☐ Unknow 9 ☐ Unknow						
S,	ires the signed	by	Part II. Other significant conditions contributing to dea	th but not resulting in the i	underlying cause gi	ven in Part I.	23e. Did tob		o the cause of death? robably 4 ∏Unknown
ecords,	w requ	Completed					24a. Was an		utopsy findings available
Ľ	The la	ошо					autopsy perform 1□ Yes 2		completion of cause of 2 □ No
N I Call	Physician; The law this certificate has b ral director, page 2 s	Be	25. Was case referred to medical examiner?				h (Check only one		1 110
0	Phys er this c eral dir	٠ <u>٠</u>	27. Manner of Death 28a. Date of		III 3 DOA		ome 5 Reside	nce 6/10Other (Spe w injury occurred	ecity) MOSPILY
VISION	arth. or: Afte	atior	2 Accident investigation	, Day Year) Injury		rk? ]Yes 2 No			
2	or Atter de fiter de Directe	Certification:	3 Suicide 6 Could not be 4 Homicide determined 28e. Place o building	of injury - At home, farm, si g, etc. <i>(Sp</i> ec <i>ify)</i>	treet, factory, office		28f. Location (Str City or Town	eet and Number or R , State)	ural Route Number,
_	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,		29a. Certifier 1—Certifying Physician: To the b						
	the Ho iin 24 l the Fu	ledical	(Check only one) 2 Medical Examiner: On the bas and manne						
	To To con	Σ	29b. Signature and title of certifier		_	\$8303	25	Od. Date signed (Mon	tn, Day, Year)
	.0		30. Name and address of person who completed cause	of death (Item 23a) (Type				7 ,	
	10		AARON S CHARLES UN	D G701 N	CHANNE	s st 7	TONSON	MD 21	204
	Sta Registr		31. Date filed (Month, Day, Year) 32. 32. 32. 32. 32. 32. 32. 32. 32. 32.	gistrar's Signature	post				
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. C. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 1336 PM **Physician** St ann IUNE JEAN ROMONA MOORE /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner t.AGNES HEALT N/A8. Date of Birth (Month, Day, Year) 07/03/1928 9. Birthplace (State or Foreign 4 Hrs 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours 1□ M 2√ F MARYLAND 78 218-22-5721 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a. State at 1X Yes 2 □ No BALTIMORE a or 28a-f she t be notified a N/A MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA CULVER STREET 21229 8 N. ed other than "natural", or items 23a event, the Medical Examiner must b Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🙀 No If Yes, Give 1 □ Never Married 2 □ Married BLACK 1 ☐ Yes 2 No Specify Specify: Baltimore, Maryland 21215-0036 þ 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 1 2 is marked other than College (1-4or 5+) MEDICAL NURSE 18. Mother's Name (First, Middle, Maiden Surname)
VIOLA WATERS 17. Father's Name (First, Middle, Last)
LEROY HORSEY Be Pages 1 and 2 should be facent of Health and intental I ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21239 19a. Informant's Name/Relationship (Type. Print) 1171 E. NORTHERN PARKWAY, BALTIMORE, MD MICHAEL MOORE / SON Health a Department of Healt Important: If item 2 any injury or other 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ARBUTUS MEM. PARK 7/05/07 BALTIMORE CO., MD 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 permit. 21. Signature of Emeral Service Licensee once 4600 LIBERTY HEIGHTS AVE, BALTIMORE, MD Inter the disase, or complications that caused the deat on one of the mode of dying, such as cardiac or respiratory arrest, k, or heart filter. List only one cause on each line. Approximate Interval Between Onset and Death Immediate use (Final disease condition resulting in death) Embolism one hour **Physician** ulmonary /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, had no to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine and Due to (or as a consequence of): ed by the attending physician detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 No 3 ☐ Ectopic pregnancy Year Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 | Yes 2 | No 3 | Probably 4 | Onknown tension cate has been sig, page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 No or Vital funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 🍇 `No **ER/Outpatient** 3□ DOA this 28a. Date of Injury (Month, Day Year) cal or Atte.

Jurs after death.

ral Director: After the by the funer. 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Certification: Division Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined filled in by 4 ☐ Homicide To the Hospital of within 24 hours at To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie D00533/2 June 28, 2007 MO 900 Caton Avenue, Baltimore, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michelle Henggeler, MD

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

32 Pegistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Nancy Dickson Mitchell 1:00 H 200 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Months Days Min 1 □ M 2 □ XF Maryland **Director** 219-34-6824 92 July 10, 1914 Usual Residence of Decedent be filed within 72 hours after death with the Maryland zil Hygiene.

1 other than "natural", or items 23a or 28a-f show went, the Medical Examiner must be notified at 10d, Inside City Limits 10a State 10b. County 10c. City, Town or Location 1 Yes 2 No Harford Director Maryland Havre de Grace 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 415 South Market Street 21078 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Yes Mo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: White ş 3 ☐Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Owner/Operator Retail Grocery Store 7 is marked other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be f Department of Health and Mental I Isabella (unk) Oliver Robert William Dickson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) M. Lee Thomas/Cousin 3021 James Run Road, Aberdeen Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Important: If It any injury or o once, 1 Burial 2 □ Cremation 3 □ Removal from State St. Mary's Church 07-03-2007 Abingdon, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McComas Funeral Home, P.A., 1317 Cokesbury Road, Abingdon, Maryland 21009 that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, is on each line. Part1. Enter the disease, or complication shock, or heart failure. List only one eau Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examine Sequentially list conditions, if any, leading to immediate caus. Enter or carrying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed and burial-trai Due to (or as a consequence of): physician the burial //ノブピカ*e.// プロハ*っとり Division or Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) been signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an cate has autopsy performed certificate 2 2 No 1☐ Yes To the Hospital or Attending Physician; 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 1 ☐ Yes 2X No 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient ٩ this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 1 Natural 5 Pending investigation within 24 hours are:

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier Le Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Dav. Year)

Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 2007

JUL 0

32 Registrar's Signature

YOMA

31. Date filed (Month, Day, Year)

			For		State of	of Mary			tment of H			lental Hy	/giene	Э		
			State Registrar				C	erti	ficate of I	Deatl	h		Reg. No	2007	21	73.
	Physicia	an	Decedent's Name (F	First, Middle,	Last)							2. Date of Do	Da		34-Time o	
	/Medic	al	Joseph Jan						b. City, Town, or	- Looption		July 5		. County of Deatl	11:4	5 A.™
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	Funeral		5. Social Security Num		6. Sex	7. Age (Ir	yrs. last birtho	ay)	If Under 1 Year		er 24 Hrs.	8. Date of Bi (Month, D	rth	0 Birth	place (State	or Foreign
ш	Director		143-12-251	5	1 <b>귳</b> M 2□F	8	1 Yrs	S.   N	Months Days	Hours	Min.	May 5,	192	6 New	<sup>intry)</sup> Jersey	
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	the N 28a-1 notifi	Director	Maryland   1  10e. Street and Number	Montgo er	omery	P	otomac	Т	10f. Zip Code				10g. Ci	tizen of What Co	untry?	
	3a or		29 Beman We	oods (	lourt				20854				Unit	ed State	s	
	death	Funeral	11. Marital Status	0000	12. Was Dec	cedent Ever	r in U.S.	13. Wa	s Decedent of H	lispanic C	Origin? (Spe	ecify Yes or N	-	14. Race - Amer Black, White	ican Indian,	
9	after or ite mine		1 Never Married			2 🗌 No	wwII		Yes 2 No	Specif		riiouri, c.o.,				
Maryland 21215-0036	be filed within 72 hours after death with the Maryland ntal Hygiene. Ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	d by	3 ☐ Widowed 4 ☐		Year or D	Dates:			We Hevel Occur				1 tch l	Specify: Whi		
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br	il Hygi other /ent, tl	Be C	17. Father's Name (Fir	rst, Middle, L	ast)					18. Mot	ther's Name	(First, Middle				
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lar)	and and sum		19a. Informant's Name	e/Relationsh	ip (Type. Print)		19b. M	lailing i	Address (Street	and Num	nber or Run	al Route Numi	ber, City	or Town, State, Z	ip Code)	
	s 1 and 2 of Health item 27   other tra		Mary T. Mac		ne / Wif					ls Ct				yland 20		
ore			20a. Method of Disposi 1 ☐ Burial 2 🕱		3 □Removal from	State		cremat	tory or other plac	_ i	July			ocation - City or	,	_
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Bal	permit. Page Department of Important: If any injury or once.		21. Signature of Fune	rai Sevice L	licerriee	м	00896	Robe	7 Wiscon	phrey	Funer	al Home/	Bethe	sda-Chevy MD 208	Chase,	Inc.
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	/Medical		disease or condition resulting in death)	15.7	a. Due to	(or as a co	onsequence of):	'	2501	J	الرائر	004	The same of the sa		yono	
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Box 6	The law requires that the death certific tre has been signed by the attending p bage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pr	regnant	23c. If yes, or									23d. Date of del	very	
m	death e after d for i	icia	in the past 12 mg	onths?	4□Preg	nant at tim	Fetal death e of death		ctopic pregnancy other <i>(specify)</i> _	у				Month	Day	Year
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S, P	res tha igned l	by P	Part II. Other significa	ant conditio	ns contributing to o	death but n	ot resulting in th	e unde	erlying cause giv	ren in Par	rt I.			use contribute to		
Records,	w require been sig should b	ted										1	Yes 2	No 3 ☐ Pr	obably 4 🗌	Unknown
ပ္ပ	law r	Completed										24a. Wa	opsy		topsy findings ompletion of	available cause of
E H	10 5	Co										per 1∐ Yes	formed? 2 🕱 N	death? o 1 ☐ Yes	2 ☐ No	
Vital	Physiclan: this certific ral director,	Be	25. Was case referred examiner?		Hospital:				3CI DOA Oth	ner.		h (Check only				
ō	Physral di	<u>۲</u>	1 Yes 2 No	)	28a. Date	Inpatient of Injury	2 ER/Outpa		2 DOV	4 🗆	Nursing Ho	me 5 A Res 28d. Describe		6 □Other (Spec	eify)	
on	ding l h. After funer	ţi		5 ☐ Pending investig	(Moi	nth, Day Ye			28c. Injur Wor M 1 🗆	rk?  Yes 2	□No			.,		
Division	I or Attending after death. Director: After I in by the fune	fica	3 ☐ Suicide	6 □Could n determi	ot be 28e. Plac	e of injury	At home, farm	, street	t, factory, office					nd Number or Ru	ral Route Nui	mber,
D	al or A safter Il Dire	Certification:	4 Homicide	dotomi	build	ding, etc. (8	Specity)					City or To	own, Stat	re)		
	he Hospital or A in 24 hours after he Funeral Dire pletely filled in by		29a. Certifier 1	Certifying	g Physician: To the	ne best of m	ny knowledge, o	leath o	occurred at the ti	me, date	and place,	and due to the	e cause(:	s) and manner as	stated.	(9)
		Medical	one)			nner stated		JI 111VC				Ted at the time				(3)
	To To	2	29b. Signature and titl	e of cortifier	+71				29c. Licens			112	29d. D:	ate signed (Mont	n, Day, Year)	
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	15		30. Name and address Frederick							300	Char	y Chac	o 1M	aryland	20215	6008
	Sta	te.	31. Date filed (Month,	Day, Year)	32.	Registrar's	Signature			.JUU,	cuev	y chas	E, F	er à rand	ZU013-	U7U0
	Registr				6 2007	Sec.	10	1								
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ORIGINAL

07-04984 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Jaye Lynn Mills Marquez State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar

1. Decedent's Name (First, Middle,Last) 3. Time of Death 2. Date of Death Physician/ Year Month Jaye Lynn Mills Marquez June 30, 2007 1016 hrs Medical Examiner 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Baltimore County** 11540 Philadelphia Road Lot # 12 White Marsh 9. Birthplace (State or If Under 1 Year | If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. Director 212-80-1124 Country)Maryland June 27,1966 Yrs М 2 X F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b, County Yes 2 X No items 23a or 28a-f show ust be notified at once. with the Maryland Baltimore Director 10g. Citizen of What Country? 10f, Zip Code 10e, Street and Number 21221 United States 610 Delaware Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14 Race - American Indian, Black, Armed Forces? White, etc. Never Married Yes 2 X No 4 X Divorced If Yes, Give Year Pages 1 and 2 should be filed within 72 hours after tent of Health and Mental Hygiene. 1 Yes 2 X No specify: Specify White Widowed tem 27 is marked other than "natural", traumatic event, the Medical Examiner þ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) ed Elementary/Secondary (0-12) College (1-4 or 5+) Complei 21215-0036 Manufacturing Machinist 12 Years 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jacqueline L'Heureux Aljerice Mills 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 21237 Baltimore, Maryland King Henry Circle Aljerice Mills (Father) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State filmore, crematory or other place) 1XX Burial 2 Cremation 3 Removal from State rtant: 7/5/2007 Middle River, MD Holly Hill Mem. Gdns. Other Specify Donation 5 22. Name and Address of Facility Signature of Funeral Service Licen Duda-Ruck Funeral Home of Dundalk, Inc. Dundalk. 7922 Wise Ave. Marvland Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line 'Medical Death Atherosclerotic cardiovascular disease Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last death certificate be executed nysician/Medical tending physician a XUNPENDED AMENDED, 27, perME, g869, 7/26/07 II Box 68760. IF FEMALE: 23d. Date of delivery 23c, if yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? Ectopic pregnancy Live birth Month Day Year Fetal death Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 ✔ Unknown signed by the att be detached for Unknown P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 Yes 2 No 3 Probably 4 V Unknown ed of Vital Records, 24b. Were autopsy findings available 24a. Was an Complet prior to completion of cause of autopsy has performed? death? page ✔ Yes 2 No 1 🗸 Yes No 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: Other4 DOA Nursing Home 5 \_\_ Residence 6 ✔ Other: Scene Inpatient 2 ER/Outpatient 3 this 2 1 V Yes 2 No 28a. Date of Injury (Month, Day, Year 27. Manner of Death 28b. Time of Injury 28c. Injury at Work' 28d. Describe how injury occurred cation: Division 1 X Naturai Pending filled in by the 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Certific 3 Could not be Suicide determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ca 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

To the Hospital or Attending Physician: within 24 ho To the Fune completely f

gistrar's Signature

and manner stated

mi

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Ling Li, MD

State Registrar 111 Penn Street, Baltimore, MD 21201

29c. License number

O.C.M.E.

29d. Date signed (Month, Day Year)

July 1, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Milwicz Joseph /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner IGNY Baltimore Washington Med. Ctr. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1⊠M 2□F Sept18,1940 Maryland Director 218-36-7949 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hyglene.
Important: If Item 27 is marked other than "natural;" or items 23a or 28a-f show amount intry of the 27 is marked other than "natural;" or items 25a or 28a-f show injury or other traumatte event, the Medical Examiner must be notified at 1 ☐ Yes 27 No Md. Bowie Prince George's Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20716-1837 U.S.A. 16105 Pond Meadow Lane Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. MYes 2 No fryes, Give 958-85 Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Department of Elementary/Secondary (0-12) College (1-4or 5+) Defense- NSA 12th 2yrs <u>Analyst</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Adam S. Milwicz Anna Sobolewski 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dixie Milwicz - Wife 16105 Pond Meadow Lane Bowie, Md. 20716 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington National9-27-2007|Arlington,Virginia 22. Name and Address of Facility Kaczorowski Funeral Home, PA 21. Signature of Funeral Service Licensee Poclac Tolunt 1201 Dundalk Ave. Baltimore, Md. 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Examine After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 2 Fetal death 1 Live birth in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a. Was an 1∏ Yes or Attending Physician; 25. Was case referred to medical 26. Place of Death (Check only one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Inpatient ဥ 1 Tes 2 ER/Outpatient 3∏ DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation (Month, Day Year) 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director: 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital 29a. Certifier Fertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifie

Registrar

31. Date filed (Month, Day, Year) JUL 0 6 2007



30. Name and address of person who complete cause of death (Item 23a) (Type, Print)

07-05005 Rosalind McGowen

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2007 21737

			- For State			Certifi	icate of De	ath		Reg	ı. No.		
Dh	nysicia		egistrar I. Decedent's Name (First, Midd	e,Last) .					2	2. Date of Death			3. Time of Death
Medical E			Roseland Mc Gowen				Month Day Year 2350 hrs						
"			4a. Facility Name (if not institution	n give stre		- 1	4b. C	ty, Town, or Lo	cation of Death		4c. County	of Death	1
			Harbor Hospital	ii, give stree	ot and manner,		l l	Itimore City			N	4	
				2.0		(In yrs. last t			If Under 24Hrs.	8 Date of Birth	(MM/DD/YYY)	9. Bir	thplace (State or
	neral		5. Social Security Number	6. Sex		(in yrs. iasi i		onths Days	Hours Min.	o. Dato o. Data	·(IVIIVII DD/ / / · ·	Foreig	on ,
Dire	ector	-	119.74-5204	1M	2×F 4	8	Yrs.			Citation 2	1.1958	Co	untry Mary And
			Usual Residence of Decedent								12		
20	au's	Г	10a. State 10b. County		1		wn or Location						10d. Inside City Limits
	₩ 10 M	. /	TARYLAND NE	r		Bart	MORE						1 Yes 2 No
LO E	or 28a-f show any fied at once.		TARYIAND NIF			101/11		, Zip Code		10	g. Citizen of W	hat Cou	ntry?
Mar	r 28;	ě	1 . 0 .		Lank			21226	•		USA		
n the	ms 23a or 28a-f sho be notified at once		1202 PRUDENCE		neer					-17 Mar - No.		- Amor	ican Indian, Black,
with	ms 2 be n	Funeral	11. Marital Status		Was Decedent E Armed Forces?	ver in U.S.			nic Origin? (Spe Nexican, Puerto F		Whit	e, etc.	
deat	r ite	Ē	1 Never Married 2 N	1	Yes 2>	< No		_			Afric	on	American
fler	l", o		3 Widowed 4 Di	vorced If Ye	s, Give Year			2× No			здесну.		
hours after	a ta	ğ	15. Decedent's Education (Spe	cify only high	ghest grade comp	oleted) 16	a. Decedent's U	sual Occupation	n (Give kind of wo	ork done	16b, Kind of B	usin <b>es</b> s/	Industry
2 ho	Ex Ex	홢	Elementary/Secondary (0-12)	-	College (1-4 or 5-	+)	0		O NOT discretific	su)	.1.		
)36 hin	than edical	힐	12 th		NIA		D150.				MA		
5-0036 led within 7	ther c M	Completed	17. Father's Name (First, Middle	e, Last)				18	.Mother's Name	(First, Middle, N	laiden Surnam	e)	
1215-0036 Id be filed within 72	dental Hygiene. narked other than "natural", or ite event, the Medical Examiner must	Be	Kaymond He	Consi	E) Sp			2	IDEA	Johns	HEG.	علمك	لير:
12 ad be	dent nark ever	라	19a, Informant's Name/Relation	ship (Type.	Print )		19b. Mailing Ad	ress (Street a	and Number or R	ural Route Num	ber, City or To	wn, Stat	e, Zip Code)
H MD 2	Health and Mental Hygiene. item 27 is marked other the traumatic event, the Med	-	12.100 1/-1/	, , , , ,	,	Į	4202 Fb	udence.	Great.	Bulm	er MAK	ulm	1 21006
MD ad 2 she	Health item 2'	-	20a. Method of Disposition			20b Pla	ce of Dienosition	(Name of ceme	terv	Date	20c. Location	- City o	r Town, State
	of He If ite			n 3 F	Removal from Stat	te Kin	g Menor	el Par	برأ أحا	m 4 . 6	11 11		m. 10
non ki	nt:		4 Donation 5 Other 3			1	1 21011	_	JUJY	07,2007	abord/A	celel, .	MARGIAND
.=	Department Importants injury or ot	- 1	21 Signature of Funeral Service	e Licensee			22. Name	and Address o	f Facility	DONAL SEL	ي ڏي		,
Balti Permit.	를 를 들		Millell m.	1100	eace	,	2105	w. Fran	of Facility Wine Full	+- BAIt	more	217	12-9
Phys	sician	$\dashv$	23a, Part I. Ent., the disease, of	r complicati	ons that caused t	he death. D	o not enter the n	ode of dying, s	uch as cardiac or	respiratory arre	est, shock, or h	eart	Approximate Interval
	edical	- 1	23a. Part I. Ent. the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Lift only one cause on each line.  Approximate Interval Between Onset and Death  Death										
	miner		Immediate Cause (Final diseas or condition resulting in death)				LOH						
V			of condition resulting in death,	Due	to (or as a conse	quence or).							
0		<u>.</u>	Sequentially list conditions,	D. Due	to (or as a conse	quence of):		-					
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) o a	physician the burial	/Medica		#1	3c. If yes, outcom			3009, 1/2	0/0/ 11		23d, Date	of delive	erv —
5 8 - 31794 (30) <b>Records</b> , <b>P.O. Box 68760</b> , The law requires that the death certificate be	g ph	١	IF FEMALE: 23b. Was decedent pregnant in		Live birth	ie oi pregna	2 Fetal	leath 3	Ectopic pregna	ncy	Month		Day Year
14 (32) <b>Box 68</b>	ndin Ise a	sician	past 12 months?	4	Pregnant at	time of deat	h 5 Other	(Specify)					
OX eath	e atte for u	/sic	1 Yes 2 No 9 🗸 U	nknown g			o Cilor	(-)//					
31794 (. s, P.O. Box	ned by the attending detached for use as	Phy	Part II. Other significant cond	litions cor	ntributing to death	but not res	ulting in the unde	erlying cause gi	ven in Part I.	23e. Did to	obacco use cor	ntribute 1	to the cause of death?
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58-2 Records,	s been should	Completed								auto	osy	prior to	completion of cause of
	e has ge 2 sl	Ę									rmed?	death?	
₹.	ificat r, pa		25. Was case referred to medi	201	<del></del>			26.Place	of Death (Check	only one)			
Oume) of Vital	certi	Be	examiner?	Hosp	oital:	-1 2 2	R/Outpatient 3		Mhan -	ng Home 5	Residence 6	Oth	ner:
(15t nounc	al di	ြို	1 ✓ Yes 2 No		i inpade		28b. Time of Injur		y at Work?	-	how injury occ		
To lo	Afte		27. Manner of Death  1 Natural 5 Death		28a. Date of Inju (Month, Day,Y	ear)	200. Time of ma	·	es 2 v No				
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Division tal or Attendit	ter d irect n by	≟		ould not be	28e. Place of In	jury - At hon	ne, farm, street,	actory, office bu	uilding, etc.				Rural Route Number, City
THE POINTS	irs af	Certification:		termined	(Specify) f	ound at	residenc	e		4202 Pru	idence St	. Cur	tis Bay, MD
The idea	within 24 hours after death.  To the Funeral Director: After this certificate I completely filled in by the funeral director, page		29a. Certifier	Physician:	To the best of m	y knowledge	e, death occurred	at the time, da	te and place, and	due to the cau	se(s) and man	ner as si	tated.
19	nin 2 the F	<u> </u>	(Check only one) 2 ✓ Medical E	xaminer:On	the basis of exa	mination and	d/or investigation	, in my opinion,	death occurred	at the time, date	and place, an	d due to	the cause(s)
To	To To	Medical	29b. Signature and title of cert	an	d manner stated.			29c. License					Month, Day, Year)
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			my m	4	nD						1		
r 04			30. Name and odress of pers	on who com	pleted cause of c	death (Item 2	23a)	D. 10	AD 04004				
0-1			Ling Li, MD Assis	tant Med	ical Examine			Baltimore, I	VID 21201				
	S	tate	31. Date filed (Month, Day, Ye	Da one	32. Registra	-	A	- 1					
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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** Doris Ruth Nadolny 200 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1□M 2**X**F 213 01 6415 87 Maryland Director 04/23/1920 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County items 23a or 28a-f show ner must be notified at 1 ☐ Yes 2 ☑ No Maryland Baltimore Essex Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 812 North Marlyn Avenue 21221 Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status ☐Yes 2X No Yes, Give 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🔼 No 'natural", or Specify. white Specify. þ 3 Widowed 4 Divorced ear or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper Hospital 12 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sadie Brown Richard Mac Cubbin 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 812 N. Marlyn Avenue Essex Maryland 21221 permit. Pages 1 and 2 Department of Health a Important: If item 27 is James Nadolny (husband) or other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Injury ( 4 □Donation 5 □ Other (Specify) 7/3/2007 Bayview Crematory Inc <u>Baltimore Maryland</u> 21. Sign 22. Name and Address of Facility re of P Service icense Bruzdzinski Funeral Home PA 1407 Old eastern Avenue Essex Maryland 21221 Approximate Interval Between Onset and Death plicatio s in t caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, y one cause on each line. nter the disease, or or heart failure. List 23a. Pil ause (Final Immedia **Physician** as a consequence of): disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to initional cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 ☐ Probably 1 ☐ Yes 2∏ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was ar 25. Was case referred medical examiner? 26. Place of Death Check onl one Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2**□**√No 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To After this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 2 Accident

Hospital or Attending Physician: The law requires that the death certificate be executed

P.O. Box 68760,

Division or Vital Records,

Health and Mental

6 □ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Square Prive Baltimore MD. 21237

10

State Registrar

29b. Signature

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month ELLEN ISABELLE NULL 1:05 P<sup>M</sup> 2007 JULY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CARROLL CARROLL HOSPICE - DOVE HOUSE WESTMINSTER if Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months 1 □ M 2 🔽 **Director** 213-09-5389 MARYLAND 90 7/28/1916 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits rral", or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☐ No Director WESTMINSTER New Windsor CARROLL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1155 WESTERN CHAPEL RD. 21776 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No þ 3 X Widowed 4 ☐ Divorced WHITE "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiens Important: If Item 27 Is marked other the any Injury or other traumatic event, the once. SEAMSTRESS 11 SEWING FACTORY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) WALTER COPPERSMITH SUSIE B. NYGREN ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2,1776 19a. Informant's Name/Relationship (Type. Print) 1155 WESTERN CHAPEL RD., NEW WINDSOR, MD DEBORAH L. SIMS -DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 【XI Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) SOUTH CARROLL CREMATORY WINFIELD, MD 21. Signature of Funeral Service License 22. Name and Address of Facility FLETCHER FUNERAL HOME, 254 E. MAIN ST., WESTMINSTER, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Aspuration /Medical Examiner Advanced nev Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the Hospital or Attending Physiclan: The law requires that the death certificate be executed physician and s the burial-trans Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 4☐Pregnant at time of death 5 ☐ Other (specify) Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an certificate ha irector, page 2 autopsy perform 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other:  $_{4}$  Nursing Home  $_{5}$  Residence  $_{6}$  XlOther (Specify)  $_{1}$  Hospice 2**54** No ို 1 | Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death
1 Natural
2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Certification: Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation after death. 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral D completely filled in 29a. Certifier Certifying Physician: To the best of my knowledge, deg urred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only ☐ Medicai Examiner: On the bases f examination and/o igation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D37949 (Item 23a) (Type 30. Name and address of person cut hem Suta 4201 Westmin

Registrar

Day,

MD, 21157

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 4:40 Marjorie 30 Hunter Patterson 2007 June /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Bethesda Montgomery Suburban Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 1□M 25F **Funeral** 205-22-655 December 5, 1922 West Virginia Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 Yes 2 No other traumatic event, the Medical Examiner must be notified Funeral Director Silver Spring Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 8505 Springvale 20910 USA Rd. Apt. 241 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Mever Married 2 Married 1 ☐ Yes 2 No 3altimore, Maryland 21215-0036 Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Secretary Technology 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elliott Remington Patterson Henrietta Dorothy 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Dorothy 7709 Beech Tree Rd Bethesda escia, MD 20817 20c. Location - City or Town, State Patterson/NIECE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of Important: If It any Injury or conce. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State June 30,2007 Hanover, M.D 4. Donation 5 ☐ Other (Specify) Anatomy Gifts Registry 22. Name and Address of Fecility Anatomy Gifts Registry 21. Signature of Funeral Service Licensee 60c MD 21076 7522 Connelley Drive suite 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 15 day Immediate Cause (Final Physician Pheumonio disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner UNKNOWN COPD Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 ☐ Ectopic pregnancy Month Year 5 ☐ Other (specify) o 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of eutopsy death? 1 ☐ Yes 2□No Division or Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Manper of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☑ Natural 1 ☐ Yes 2 ☐ No death. 2 Accident after death | Director: | Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral C

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D 3189 June 30, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Congressional RD # 409 Rockille, MD Z085Z RAJVANSHI 121 31. Date filed (Month, Day, Year) 2. Registrar's Signature JUL 0 6 2007 Registrar

PATTERSON

MARTORIE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 1, 2007 2025 P Ju1y Frederick C. Parr /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Upper Chesapeake Medical Center Bel Air
Year | If Under 24 Hrs. Harford Birthplace (State or Foreign Country) If Under 1 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 X M 2 □ F Oct. 6, 1921 Maryland Director 216-14-0411 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits the Maryland 10a. State item 27 is marked other than "natural" or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Maryland Harford <u>Joppa</u> 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U. S. A.

14. Race - American Indian, 509 K. Cider Press Ct. 21085 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? Black, White, etc. 1 M Yes 2 No If Yes, Give Year or Dates: 1942 1945 1 ☐ Never Married 2 ☑ Married Specify: White 1 ☐ Yes 2 X No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Sales Dairy 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be h and Mental H Frederick C. Parr Anna Kus 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If Item 27 Is any injury or other tra once. 509 K. Cider Press Ct., Joppa, Maryland 21085 to of Disposition (Name of Date 20c. Location - City or Town, State Margaret Parr (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Cem 107/07/2007 Baltimore, Maryland 22. Name and Address of Facility Schimunek Funeral Home Inc. 21. Signature of Funeral Service Licensee 9705 Belair Road, Baltimore, Maryland 21236 Belle 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) a. Respiratory friture **Physician** /Medical Du to (or as a consequence of): Rt Lung Large Cell Carcinoma Lung with Pleural **Examiner** 2 months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last metasusis. Due to (or as a consequence of): Physician/Medical Examiner 20 YVS As bestosis ng physician and as the burial-trans Due to (or as a consequence of): Obstmctive IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9∏ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ Mô Yes 2 No 25. Was case referred to medical 26. Place of Death Check onl one Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 📉 Ño 1 Nnpatient 2 ER/Outpatient 3 DOA ဥ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. To the Hospital or Attend within 24 hours a er death To the Funeral Director: 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DO0 18424 July-2-2007 K 30. Name and address of pers of who completed cause of death (Item 23a) (Type, Print) HARFORD ROAD, FALLSTON, MD-21047

State Registrar 31. Date filed (Month, Day, Year) 0 6 2007

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32 egistrar's Signature

1908

07-05097 Megan Ann Pratt

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2007 21742

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	State of Maryland	Department of H	lealth a	nd I	Mental	Hygiene

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			L	Upper Criesapeake Medical Gerico	Date of Birth	MM/DD/YYYY)	9. Birthplace (State or
	Funera Directo			Social Security Number 6. Sex	oril 30,		Foreign Country) MD.
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	ith the	100		Lie W. B. and J. Francis H.S. 12 Was Decedent of Hispanic Origin? (Specify	y Yes or No-	14. Race White	- American Indian, Black,
	ath w	ast De		1 X Never Married 2 Married Armed Forces?	an, etc.)	1	White
	iter de	ا ا	1	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify:		Specify:	
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712	ild be Menta narke	even	ш	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or Rura	al Route Numb	er, City or Tow	n, State, Zip Code)
MD	2 shou and 1	matic		Delores Pratt Mother 610 Dogwood Avenue, Edge		Maryla	nd 21040 - City or Town, State
-		tran	h	20a. Method of Disposition	5,		
jo	ages l nt of l	other					ore, MD.
ii.	permit. Pages I and Department of Heal Important: If iten	ry or	ŀ	4 Donation 5 Other Specify  22. Name and Address of Facility  Connolly Funoral Home	o of D	undalk	РΛ 21222
ä	a de la	injury	1	4 Donation 5 Other Specify:  22. Name and Address of Facility  Connelly Funeral Home  7110 Sollers Point Re  23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or re  failure. List only one cause on each line.  Pulmonary complications of chronic drug use	Sad, Du	ndalk.	Approximate Interval
	sicia		$ \top $	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of refailure. List only one cause on each line.	sophatory and	ot, official, and	Between Onset and Death
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	_Auiiiiii		-	or condition resulting in death)  Due to (or as a consequence of):			
			F	Sequentially list conditions, if any, leading to Immediate Due to (or as a consequence of):			
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	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 but outs after death.	the burial - transit	<u>e</u>	X UNPENDED AMENDED 27, perME, g870, 8/6/07 TT			
ç	ate be	e buri	Medical	23c. If was outcome of pregnancy		23d. Date	
7	rtifica ling pl	as th		23b. Was decedent pregnant in the a Live birth 2 Fetal death 3 Ectopic pregnance	У	Month	Day Year
	<b>BOX 687</b> e death certific the attending I	or use	sici	4 ✓ Pregnant at time of death 5 Other (Specify)  1 ✓ Yes 2 No 9 Unknown			
Ċ	the de	detached for use as t	Physician/	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			tribute to the cause of death?
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	Phys	er uns eral dir	5	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 2	28d. Describe	how injury occi	urred
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i	Division of Vital Records, F.U. tal or Attending Physician: The law requires that I tal or Attending Physician: The law requires that I tal safe death.	led in	Certification:	determined (Specify)			
	Hospi 24 hou	To the Funeral Director: completely filled in by the		CO. C. Hilliam and the time date and place and	due to the cau	ise(s) and mani	ner as stated. d due to the cause(s)
	il il	o the	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death of some and manner stated.	THO LINE, GAN	29d Date si	igned (Month, Day, Year)
4	F ≥ F	<b>-</b> 3	Me	29b. Signature and title of certifier  29c. License number		July 4, 2	
				Doma nu incenti, m. D. O.C.M.E.		Jan, 1, 2	
				30. Name and address of person who completed cause of death (Item 23a)  Donna M. Vincenti, MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD	21201		
				Donna IVI. Vincenti, IVID			
		S egis		St. Date lined (Wolfath, Day, 1987)			
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ORIGINAL

Division or Vital Records, P.O. Box 68760, or Attending Physician:

Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** James Wesley Price 2, July. 2007 10:00 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 9704 Inaugural Way Montgomery Montgomery Village 8. Date of Birth (Month, Day, Year) Oct. 24, 1933 If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 9. Birthplace (State or Foreign Country)
Alabama 6. Sex 1 M 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 73 418-36-2770 Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland I and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f show 10h County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Montgomery Montgomery Village 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9704 Inaugural Way United States Funeral 20886 Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 X Yes 2 No If Yes, Give Year or Dates: Vietnam 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Black ≥ 3 X Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Chief Master Sergeant U.S. Air Force 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Frank R. Price, Sr. Frances J. Brock 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If Item 27 Is rr any Injury or other traum Bridgett R. Price/Daughter 475 Chestertown Street, Gaithersburg, MD 20878 20b. Place of Disposition (Name of cemetery, crematory or other place)
Riverside National
Cemetery July 9, 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Riverside, California 2007 4 ☐ Donation 5 ☐ Other (Specify) M01346 Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850 21. Signature of Funeral Service Licensee 23a. Part1. Ent. The disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner men Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9□Unknown cate has been signed by page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed2 1 Yes 2 No 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural s after dea... ral Director: Aftr 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 📉 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of pertific 2033 completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who Martin PortiNo, M.D. 501 North Frederick Avenue, Gaithersburg, Maryland 20877 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** 9:50 AM Veronica Julia Perseghin Perkins 28, 2007 June /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Abingdon 3327 Berlin Court Harford Co. | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | May 5, 1918 9. Birthplace (State or Foreign Country) North Carolina 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□M 2录F 89 Yrs. 212-07-3887 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show or items 23a or 28a-f show aminer must be notified at 1 ☐Yes 2 No Director Abingdon Maryland Harford 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 2 lamp lajury or other traumatic event, the Medical Examiner must be n once. 21009 United States 3327 Berlin Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ White 3 Midowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home 6 Years Housewife 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Napoleon Perseghin Adele Brandaleze ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Bel Air, Maryland 21014 Coreopsis Court Patrick J. Perkins (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Buria! 2 ☐ Cremation 3 ☐ Removal from State 6/30/2007 Baltimore, Maryland Oak Lawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ischemic cardiomyonathy **Physician** Year /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): P.O. Box 68760. attending physician Physician/Medical the IF FEMALE: If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 5 ☐ Other (specify) 4□Pregnant at time of death the 9 I Inknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. þ funeral director, page 2 should be 1 Tyes 2 No 3 Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has certificate l 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 24 hours a 1 💆 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only and manner stated. within 2 To the I 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified

State Registrar

DHMH 17 Rev 1/2001

W. 40th St BaltimoreMD 2/211

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registral's Signature

SAMUE

31. Date filed (Month, Day, Year)

1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ichardson Month Day Year RANK 7:30A M 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE ALTIMURE NIA Medical enter If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Days 1 XM 2X Hours 238-68-7838 Yrs. N.C. 6-17-1946 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. tnside City Limits 1 Yes 2 No N/A Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 3016 Baker Street 21216 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Btack, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 📉 No 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Bethlehem Steel 12th grade N/A Steel Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Frank Richardson, Sr Louvenia Reid 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3016 Baker Street Baltimore, Md 21216 Roberta Richardson - Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Ellwood 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 7-9-2007 Goldsboro, N.C. 21. Signature of Funeral-Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Avenue Baltimore, MD 21215 pelle 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Finat disease or condition resulting in death) Due to (or as a consequence of): Sequentially list our dilors if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an 1□ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospitat: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ₺ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

/Medical Examiner sicien and burial-transit The law requires that the death certificate be executed attending physi P.O. F certificate has been signed by the a rector, page 2 should be deteched in Division of Vital Records, or Attending Physician: : After this certific funeral director, s after dea... ral Director: Afte filled in by within 24 hours a To the Funeral I completely filled Hospite the the

Physician

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Examiner

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**Funeral** 

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or 28a-f show

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Medical Certification; To

IT is marked other than "natural", or iteme 23e or 28e-f ehov traumatic event, the Medical Examinar must be notified at

with the Maryland

death

Pages 1 and 2 should be filed within 72 hours after

and Mental

Item 27 other tru

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Injury

Departi Import eny inj once.

Physician

Baltimore, Maryland 21215-0036

4 | Homicide 1 Lecrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P21146 MID 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10NG CREENESTREET BALTIMURE, MD 21201 Bernadette C. Sigton

State Registrar

31. Date filed (Month, Day, Year)

6 JUL 0

32. Registrar's Signature

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 703 P **Physician** 03 E 7 07 Charles Edward Ritzel /Medical 4c. County of Death Facility Name (If not institution, give street and number) Town, or Location of Death Examiner Himbre (1)
der 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Hours 1 € M 2 □ F Yrs. Director 215-03-3828 98 July 7, 1908 Maryland Usual Residence of Decedent r 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Directo Maryland Baltimore White Marsh 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 'natural', or items 23a or dical Examiner must be r 21162 Funeral 11704 Larch Road U. S. A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. and 2 should be filed within 72 hours after teath and Mental Hygiene.
m 27 is marked other than "natural", or iten her traumatic event, the Medical Examiner 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. ģ Specify: 3 X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Steel Company Superintendent 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Katie Bickel William Howard Ritzel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health 11704 Larch Road, White Marsh, Maryland 21162 Millard Knowles (brother-in-law) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of He
Important; If iten
any injury or oth 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 07/06/2007 | Baltimore, Maryland Gardens of Faith 22. Name and Address of Facility Schimunek Funeral Home Inc. 21. Signature Pro Service 9705 Belair Road, Baltimore Maryland 21236 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Renal Fuilre disease or condition resulting in death) Acula /Medical Due to (or as a consequence of): **Examiner** Dehy Juckion Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed Due to (or as a consequence of): burial-trar that initiated events resulting in death) Last Box 68760, physician Physician/Medical the attending pl for use as t 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 9□Unknown 5 Other (specify) Division or Vital Records, P.O. been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? <u>م</u> 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown CONSUERIUC Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No page 2 autonsy perfor 1∐ Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending investigation nours after death.

neral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral E 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) completely and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatu 743786 7.3:6.7 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Place Fil tinors Howard 1714 Mant 71 2120 i

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State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician Lillian Doris Rackl <u>June</u> 30 2007 1:25P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Gilchrist Center <u>Towson</u> If Under 24 Hrs. Birthplace (State or Foreign Country) If Under 1 Year Months Days 5. Social Security Number 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** 1 M 216 01 0622 Baltimore Co., MD Director May 6 1918 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If time 27 is anarked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Baltimore Baltimore County 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6713 Kenwood Avenue 21237 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: Completed by White 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Omi Travel 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph L. Kern Caroline M. Weinecke ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1511 Wilson Point Road Baltimore, Maryland 21220 Henry Rackl Jr 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Zion Luth. Ch. Cemetery July 5 2007 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lassahn Funeral Hone Inc 7401 Belair Road Baltimore, Maryland 21236 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, Tshock, or heart failure. List complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest only one cause on each line. Immediate Cause (Final . Cardiovascular **Physician** Arteriosderac 15 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and Due to (or as a consequence of): the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Dav in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 4☐Pregnant at time of death 5 Other (specify) Ö 9☐Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 | Yes 2 | No 3 | Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autops, performed 2X certificate has Vital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ို 2 ER/Outpatient 3 DOA Division or 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Manner of Death Certification: 1 Natural 2 Accident 5 Pending investigation 2 □ No 1 TYes Director: 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) ca (Check only and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 25643 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 555 W. Towsentown Kendale RraulknermD 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

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Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 12:10 PM Richardson Herbert Basil /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Baltimore Washington Medical Center Glen Burnie If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth March Day, Year) 914 Birthplace (State or Foreign Country) A I 5. Social Security Number 6. Sex **Funeral** Months 1 M 2 □ F 93 217-10-8541 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show 1 ☐ Yes 2 ☐ No Examiner must be notified Pasadena Director Maryland Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō 21122 USA 291 Riverside Drive 23a ( Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Black, White, etc. 1 Never Married 2 Married ō 1 ☐ Yes 2 ☑ No White Specify. Specify: ģ 3 ☐ Widowed 4 ☐ Divorced ear or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Supervisor Koppers Corp. permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygic Important: If Item 27 Is marked other i any Injury or other traumatic event, tt 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pritchert Mamie Richardson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 291 Riverside Drive, Pasadena, MD 21122 Alverta S. Richardson (spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition Julv 1 Burial 2 □ Cremation 3 □ Removal from State Elkridge, Maryland Meadowridge Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2007 21. Signature of Funéral Service License Stallings Funeral Home, P.A. Mountain Road, Pasadena, MD 21122 ter the mode of dying, such as cardiac or respiratory arrest 23a. Part . Enter the disease, complications that caused the sho k, or heart failure. List only a e cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe Yes 2 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 ☐ Yes 2 ER/Outpatient 3□ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Natural Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

spital or Attending Physician; The law requires that the death certificate be executed ours after death.

Beral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit Division or Vital Records, P.O. Box 68760, within 24 hours a

x State

Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

29c. License number

🙀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

f person who completed cause of death (Item 23a) (Type, Print) 30. Name and

and manner stated.

DHMH 17 Rev 1/2001

			For State Registrar	State of Ma	ıryland		rtment of F		Mental Hy	/giene Reg. No.	007	21750	
, a	1. Decedent's Name (First, Middle, Last)								2. Date of D	eath	Vers	3. Time of Death	
	Physici /Medic				obins	on			June	29	2007	10:29 A™	
	Examin	er	4a. Facility Name (If not institution, give Washington Count					r Location of Dea: erston	th	1	nty of Death Shingt	on	
15	Funeral		5. Social Security Number 6. S		e (In yrs. las	st birthday)	If Under 1 Year	If Under 24 Hrs	8. Date of B	irth	9. Birtho	lace (State or Foreign	
	Director		216-44-6303	⊠M 2□F	61	Yrs.	Months Days	Hours Min	May 3	31 1946	Coun	MD_	
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City.	Town or Loc	cation					0d. Inside City Limits	
	Manyla f sho	io	Maryland Washing	ıt.on	,			erstown				1 □Yes 2 No	
	r 28a	Director	10e. Street and Number	, ••••			10f. Zip Code	0,000,11		10g. Citizen o	of What Cour	itry?	
	th with		310 Cameo Drive					21740			USA		
	er dea	Funeral	11. Marital Status	12. Was Decedent 8 Armed Forces?		13. V	Vas Decedent of F f Yes, specify Cub	lispanic Origin? (S an, Mexican, Pue	Specify Yes or N rto Rican, etc.)		lace - Americ lack, White,		
36	be filed within 72 hours after death with the Maryland tial Hyglene. ad other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	10	1	☐ Yes 2☐ No	Specify:		Spec	cify: Wh	ite	
5-0036	72 hou natura ical E	ted	15. Decedent's Ed (Specify only highest gra			16a. Deced	lent's Usual Occup kind of work done	nation	orkina	16b. Kind of	Business/Inc	dustry	
2	ithin ne.	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	Tife. D	OO NOT use retire	d) -	g	Cons	.+	ion	
LZ D	filed w Hygie ther th	S	17. Father's Name ( <i>First, Middle, Last,</i>	)		'	Carpente	•	me (First, Middl		struct	1011	
a	d o d o	To Be	James W.	Robinson				Alice	•	ck	,		
Maryland	2 should and Men Is marke aumatic	_	19a. Informant's Name/Relationship (	Type. Print)		19b. Mailin	g Address (Street	and Number or F	lural Route Num	ber, City or Tow	vn, State, Zip	Code)	
	s 1 and 2 should if Health and Mer Item 27 Is marke other traumatic		Daniel L. Robinso	n (brothe			Magothy [ sition (Name of	<u>Beach Roa</u>					
Baltimore,	m O L		20a. Method of Disposition  1 □XBurial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specification 1)		cer	netery, c <del>i</del> en	natory or other plants  Cemeter	ov i out	y 05 007	20c. Location Glen Bu	,	Maryland	
Balt	permit. Page Department ( Important: If any injury or once.		21. Signature of Funeral Service Licer	1/8	1	V	Name and Address Name and Address Name		Stalling	s Funer	al Hor	ne, P.A.	
\$	*		23a. Parn . Enter the disease, or comshock, or heart failure. List only	plications that caused	the death.						10 2116	Approximate Interval Between	
	Physician	4	Immediate Cause (Final									Onset and Death	
	/Medical Examiner	er	resulting in death)  Due to (or as a consequence of):										
			Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):										
/	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C									
Ď,	ficate be executed physician and s the burial-transit	Exa	resulting in death) Last	equence of):									
58760,	icate b physic s the b	dical	•	d									
ROX	death certifik e attending p d for use as	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome						23d. I	Date of delive	ery	
	death e atte	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 4□Pregnant at 9□Unknown			Ectopic pre <b>g</b> nanc   Other (s <i>pecify</i> ) _	У			Month	Day Year	
л Э	w requires that the de been signed by the should be detached	Phy	9 Unknown	· · · · · · · · · · · · · · · · · · ·	it not recult	ing in the un	nderlying cause giv	en in Part I	23e Did	tobacco use co	ontribute to the	as cause of death?	
ďS,	iaw requires that as been signed b 2 should be deta	þ									cco use contribute to the cause of death?  2 No 3 Probably 4 4 hrknown		
Hecords,	w requ	lete			-				24a. Wa	s an 24	h. Were auto	psy findings available	
	The lav te has bage 2 :	Completed					<del></del>		aut	opsy formed? 2 No	prior to co death? 1 ☐ Yes	mpletion of cause of	
		BeC	25. Was case referred to medical examiner?					26. Place of De	eath (Check only		1 1 1 6 3	20110	
o_	> Sp	70	1 Yes 2 Ho	Hospital: 1 ☐ Inpatie				er: 4 Nursing	Home 5 ☐ Res	sidence 6 🗆 0	Other (Specif	y)	
2	ding Ph h. After thi funeral	ion:	27. Manner of Death  1 ☐ Natural 5 ☐ Pending	28a. Date of Injui (Month, Day		8b. Time of Injury	28c. Inju	yat k? Yes 2 ∐No	28d. Describe	how injury occ	curred		
/Islon	Attend death cctor: y the	ficat	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of inju	ıry - At hom	e, farm, stre		7e5 2 10	28f. Location	(Street and Nu	mber or Rura	al Route Number,	
2	tal or safter al Dire	Certification:	4 ☐ Homicide determined building, etc. (Specify)					City or Town, State)					
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Medical		ysician: To the best on niner: On the basis of and manner sta	examination								
	To th within To th comp	Me	29b. Signature and title of certifier				29c. Licens			29d. Date sig			
			- Lact	0			216	9019		3001	£ 3 o	2007	
	3		30. Name and address of person who	CM MD	34	0 1	MILL S	7 HA	GERS	704~	, m	021740	
0	Sta		31. Date filed (Month, Day, Year)	32. 201stra	ar's Signatu	re	-			-			
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**ORIGINAL** 

DHMH 17 Rev 1/2001

Registrar

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ORIGINAL

Slower & Sparke

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** Harold J. Reinhardt 0702 A M JULY 2 Z007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner AMBRIDGE HOSPITAL DRCHESTER DORCHESTER GENERAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Apr 7, 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) Social Security Number **Funeral** Days Hours 1**☑** M 2□ F 75 1932 218-26-8217 Apr Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f ehror any injury or other traumatic event, the Medical Event. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County MD Dorchester 1 ☐ Yes 2√ No Taylors Island Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4427 Hoopers Neck Road 21669 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 150-5 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: white **'**50-54 Completed by 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) unk unk (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Phillip Reinhardt Edith May Legembil မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harold Reinhardt Jr/son 5627 Anthony Avenue Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☑ Donation 5 ☐ Other (Specify) 3 ☐Removal from State 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street 21. Signature of Funeral Service Ronal d irector Baltimore, MD 21201 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate Tuse (Final disease or condition resulting in death)

A Y LEVIOSC / LEVIOL HEAVY DISEASE. **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (unas a consequence of) Examiner Physician: The law requires that the death certificate be executed the burial-trar and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 ☐ Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 4. Unknown 2 No 3 Probably 1 Yes page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☐ No. 24a, Was an autonsv performe After this certific funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours af er dear To the Funeral Director. completely filled i by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier -07 2 30. Name and address of person w o completed cause of death (Item 23a) (Type, Print) CAMBRIDGE 503 BYRN THANWY NOMAN 2. Registrar's Signature 31. Date filed (Month, Day, Year) State 0 6 200 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Year 112/bc 5:15 P 67 /Medical 4a. Facility Name (Institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner OakCrest Village Parkville Baltimore Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day) 6. Sex **Funeral** Hours 1 □ M 2 🛛 F 79 Yrs 08-11-1927 Director 214-26-3265 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2√∑ No Funeral Director Mary land Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8832 Walther Blvd. S225 21234 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. and 2 should be filed within 72 hours after ealth and Mental Hygiene.
n 27 Is marked other than "natural", or ite 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: White 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygier Important: If item 27 is marked other th any Injury or other traumatic event, the once. Bookkeeper Insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Manning W. Hall Evelyn H. Hutchins 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robin S. Cooney (Daughter) 835 Staffordshire Rd Cockeysville, MD 21030 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Bel Air Memorial Gar. 7-16-2007 Bel Air, Maryland 22. Name and Address of Facility Schimunek Funeral Home of Bel Air 21. Signature of Funeral Service Licensee Stafanie Inc. 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** phrumon /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months 1 Yes 2 No 4☐Pregnant at time of death Month Day 5 Other (specify) 9☐Unknown The law requires that the 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has performe certificate 2 the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospital: 1 ☐ Inpatient Other: 1 Yes 2 No ٩ 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After (Month, Day Year) 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours af

To the Funeral D

completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) and address of person who completed cause of death (Item 23a) (Type, Print) Bring with the MD 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar 0 6 2007 DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 200 /Medical Mary L. Stilson
4a. Facility Name (If not institution, give street and number) Examiner Baltimore eaale Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Months Days Hours 1 □ M 2 F 212-44-2424 61 Aug.30,1945 Maryland Director Usual Residence of Decedent 10c, City, Town or Location 10a. State 10d. Inside City Limits 28a-f show must be notified MD Baltimore Essex 1 ☐Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 411 Lorraine Ave. 21221 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2/2/1/No Specify. þ 3 ☐ Widowed 4 ☑ Divorced ear or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unemployed disabled 12th d 2 should be filed w th and Mental Hygier 7 Is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic evonce. Robert Parrott Mary E. Stansbury 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jamie L. Riley /daughter 411 Lorraine Ave. Baltimore MD 21221 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Bayview Crematory 7/3/07 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 300 Mace Ave. Balto. Connelly Funeral Home of Essex 21221 Approximate Interval Between Anset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed Division or Vital Records, P.O. Box  $68760^{\prime}_{S}$ attending physician and for use as the burial-tra Due to (or as a consequence Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performe death? 1 ☐ Yes certificate 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ပ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Matural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Yes 2 No neral Director: / 2 Accident 6 □Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29b. Signature and title of certifie

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State Registrar 30. Name and address of person who completed of

31. Date filed (Month, Day, Year)

MCCluskey

9000 Franklin Square drive Baltimore, Md

use of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** DID 200 /Medical Facility Name (If not institution, give street and number) 4c. County of Death ranklinso 4b. City. Town, or Location of Death Examiner Baltimore Dr. 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday **Funeral** 1 M 2 D Year Days 216.32.2154 71 Maryland Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County show r 28a-f show notified at Md Baltimore Nottingham 1 ☐ Yes 2 TNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be 5 Joppawood Court 21236 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or ther any injury or other traumatic event. the Medical Evention 1 ☐ Yes ※X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. White Specify: 2 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Cashier Retail 8th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Henry Gentry Maratha Christina McKenzie ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Ronald Young /son Joppawood Court Nottingham MD 21236 20b. Place of Disposition (Name of cemetery, crematory or other place)
Holly Hill Cemetery 6/30/07 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore MD 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 300 Mace Ave. Balto. MD 21. Signature of Furieral Service Licenses Caly Connelly Funeral Home of Essex 21221 23a. Pa h . Enter the dise s , or con p shock, or heart failur . List and tions that caused the crath. Do not enter the mode of dying, such as cardiac or respiratory arrest, ne cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Renal Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner neumoni Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner of IRR HOSIS burial-tran Due to (or as a consequence of) physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) been signed by the a should be detached f 1 ☐ Yes 2 ☐ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 ☐ Yes 3 Probably 4 Unknown Anemi 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No CARDIO MY UDATH **TSCHEMIC** page 2 s autopsy performed certificate 25. Was case referred to medical examiner? the funeral director, Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural (Month, Day 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Director filled in by

Certification: 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

The dical Examiner: On the basis of examination and/or investigation in my opinion, death account at the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d, Date signed (Month, Dav. Year) 29b. Signature and title of certifies DUO 5837

State Registrar

DRMYa

31. Date filed (Month, Day,

2.

Thein

9000 From Klin 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Square

Donne

MD21237

Baltimuse

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Maryl		artment of H			giene Reg. No	007	21756
			Registrar  1. Decedent's Name (First, Middle, Last	)		rimodio or	Douin	2. Date of Dea			3. Time of Death
40	Physic		Dolores M. S					Month	Day	Year	4:05 PM
	/Medi Examir		4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of [	Death	_	unty of Death	1103 F
	LAGIIII	iei	FRANKLIN SQUA	RE HOSD	,TAI	Rose		Uro Lo e a cele	BA		IORE
	Funeral		5. Social Security Number 06. Sec. 15		yrs. last birthday) 76 Yrs.	If Under 1 Year Months Days		Min. 8. Date of Birt	<sup>h</sup> ∕1 <sup>Year)</sup> 9 3	Coun	**
	Director		Usual Residence of Decedent		, ,			buryz	1,155	Mar	yland
	/land low		10a. State 10b. County	100	. City, Town or Lo	ocation				10	0d, Inside City Limits
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notitled at	tor	MD Baltimo	ore	Middle	e River					1 ☐ Yes 2 XNo
	or 28	irec	10e. Street and Number			10f. Zip Code			10g. Citizen	of What Coun	try?
	th will	al C	305 Tidewater	Lane		21220	)		USA		
	r dea	Funeral Director	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of H	lispanic Origin an, Mexican, F	n? (Specify Yes or No- Puerto Rican, etc.)	14.	Race - America Black, White,	
36	s afte	by Fu	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🙀 No If Yes, Give		1 ☐ Yes 2X No	Specify:	,		ecity: Whi	
21215-0036	hour tural'	d b	15. Decedent's Edu	Year or Dates:	16a Dece	dent's Usual Occur	agtion	-		of Business/Inc	
15	in 72 in mar ledic	Sete	(Specify only highest grad	le completed)	(Give	kind of work done DO NOT use retire	during most of d)	f working	TOD. KING C	Ji Business/inc	lustry
212	with iene. thar	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		emaker	,		own	home	
ğ	e filed I Hyg other	Be C	17. Father's Name (First, Middle, Last)				18. Mother's	Name (First, Middle,	Maiden Sur	rname)	
lar	old be Aenta Aenta rked tic ev	To B	John L. Greif				Elsi	e Nagel			
Maryland	12 should be filed within 'h and Mental Hygiene. 7 Is marked other than " 7 traumatic event, <u>the Me</u> g		19a. Informant's Name/Relationship (T)	í				or Rural Route Numbe			
	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hyglene. If Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		Joseph Swann /	husband	305	Tidewa	ter L	ane Balt	o. MD	2122	0
=	of Hi		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F	Romoval from State		matory or other pla		Date		on - City or To	
Ï.	Pages Iment of I tant: If Ite jury or of		4 □ Donation 5 □ Other (Specify)			v Cremat	-:			more l	
Baltimore,	permit. Pages 1 and Department of Health Important: If Item 27 any injury or other tt		21. Signature of Funeral Service Licens	iee /	1 2	2. Name and Addre	ess of Facility	300 Mace	Ave.	Balt	imore MD
100	9		23a. Part I. Enter the dise se or comp	cations that caused to	death. Do not en			eral Home		Essex	Approximate
	<b>Sharafatan</b>		23a. Par 1. Enter the dise se, or smp, shock, or heart failure. List only Immediate Cause (Final	ne cause on each line	n Teomacoss				.001,		Interval Between Onset and Death
	Physician /Medical	П	disease or condition resulting in death)	a. Kespir, Due to (or as a con	A I OR Y	+1154	11-10	iency			
	Examiner	Ш		A /_ \ S	isoquerioe on.						
	υÇ	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cor	sequence of):						
np	The law requires that the death certificate be executed te has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Examiner	that initiated events	c							
0,	e exe		resulting in death) Last	Due to (or as a cor	sequence of):						
8760,	ate b	dical		d							
9 X	leath certific attending p	Me	IF FEMALE:	22a. If you guitoomo of pr	ognonov						
Вох	attend for us	Physician/Me	in the past 12 months?	23c. If yes, outcome pf pro 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time	Fetal death 3[	⊒Ectopic pregnanc	у		23d.	Date of delive Month	ry Day Year
0	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐Unknown	ordeam 5t	Other (specify)					
٦.	res that the de igned by the a be detached		Part II. Other significant conditions co	ntributing to death but not	resulting in the u	inderlying cause giv	en in Part I.	23e. Did to	bacco use o	contribute to th	e cause of death?
Records,	uires sign Id be	Completed by						1 🗆 Y	es 2 N	lo 3 Prob	ably 4 □Unknown
O	w requ	lete						24a. Was a	an 2	4h Were autor	nsy findings available
Re	he lav e has	티						autop perfo	sy rmed?	death?	osy findings available npletion of cause of
			25. Was case referred to medical				26 Place of	1 Yes f Death (Check only of	2 No	1 🗆 Yes	2 No
>	Physiclan: r this certifica ral director, I	To Be	examiner?	Hospital: 1 npatient	2 ☐ ER/Outpatie	nt 3□ DOA Oth	OF:	ing Home 5 ☐ Resid		Other (Specifi	d
	g Ph er thi		27. Manner of Death	28a. Date of Injury	28b. Time o			28d. Describe h			7
ion	Attending F r death. ector: After by the funer	iệ	1 Natural 5 Pending 2 Accident investigation	(Month, Day Yea	r) Injury		rkr  Yes 2∐No	,			
Division	I or Attendi after death. Director: A I in by the fu	ifica	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - / building, etc. (Sp	At home, farm, st	reet, factory, office		28f. Location (S City or Tow		umber or Rura	l Route Number,
ō	talor safte al Dir	Certification:		building, oto. (o)				City of You	n, otate)		
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check only one) Certifying Phy 2 Medical Exam	sician: To the best of my iner: On the basis of exam	knowledge, deat mination and/or ir	th occurred at the tinvestigation, in my	me, date and popinion, death	place, and due to the occurred at the time,	cause(s) and date and pla	d manner as st	ated. the cause(s)
	thin 2 thin 2 the mple	Med	29b. Signature and title of certifier	and manner stated.		29c. Licens	e number		20d Date si	gned (Month, i	Day Voarl
	F ≥ F 8	-	Digital of certifier	11/1/	nnn				7/	1) 5/2	() () 7
			On Name and History	Unkles	1010	RE.	5 00	200	_//_	03/2	00
	6		30. Name and address of person who co	0 0000	(item 23a) (Type,	Print)	1 4 14 -	DA A.	IT'	. IA	41237
	Sta	ate	31. Date filed (Month, Day, Year)	32. egistrar's S	ignature	IIN SEL	ARE	DR DA	//1 M	ORE	19 91921
	Registr		un 0 6 20	107   Me.s.	K A	DONEL D					

DHMH 17 Rev 1/2001

 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show all proportant in the context than "natural", or items 23a or 28a-f show all proportant in the manualty event, the Medical Examiner must be notified at once.	
To the Hospital or Attending Physician. The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	

			For State Registrar		State o	f Mary	land / De <i>C</i>	-	ent of F ate of			Mental H	ygiene Reg. No	200	7	21	157
7		2.	Decedent's Name (First, in the content of the	Middle, Las	st)							2. Date of D	eath			3. Time o	f Death
	ysicia Vedic		Michael Arthur	Simm	ons, Sr.							June	26,	2007	ear	5:34	a <sup>M</sup>
	amin		4a. Facility Name (If not inst	itution, give	street and nu	mber)		4b. 0	City, Town, o	r Location	of Death	1	4c.	County of	Death		
Fun			Laurel Regional 5. Social Security Number	6. S		7. Age (Ir	n yrs. last birtho	Mon	Laure nder 1 Year ths Days		r 24 Hrs. Min.	8. Date of B	Prince Ge-		. Birthpl	ace (State try)	or Foreign
Dire	religible to the second	9	220-42-3014 Usual Residence of Decede	nt								March 1	3, 19	+5	Mary	rang	
yland	të		10a. State 10b. Co	ounty		10	c. City, Town o	r Location							10	Od. Inside C	-
e Ma	tified	cto	Maryland Pr	inces	Georges		Laurel									1 <b>□x</b> (es	2 □ No
if the	96 19	Director	10e. Street and Number					10f	. Zip Code					izen of Wha		•	
ath w	nust	rai	15967 Dorset Ro	ad	40 IV D		:- 110	10.111		707	-1-1-0 (0			ed Stat			-
Baltimore, Maryland 21215-0036  sermit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene.  mportant: If item 27 is marked other than "natural", or items 23a or 28a-f show	event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □  3 □ Widowed 4 ☑ Dive		12. Was Dec Armed Fo 1 ☐ Yes If Yes, Gi Year or D	orces? 2 ☑ No ve	r III 0.5.	If Yes,	specify Cuba	Specify.	an, Puert	pecity Yes or N o Rican, etc.)	10-		White, 6		
<b>5-0</b> 72 hr	dical	etec	15. Dec (Specify only i	edent's Ed	lucation de completed)		16a. Do	ecedent's l	Usual Occup f work done o T use retired	ation during mos	st of wor	king	16b. K	ind of Busir	ness/Ind	ustry	
within she.	e Me	Completed	Elementary/Secondary (0-	-12)	College (	1-4or 5+)		ntract		7)			Pa	inting			
filed v	nt, th	ပ္သ	17. Father's Name (First, Mi	ddle, Last)				10100		18. Moth	er's Nan	ne (First, Middi					
aryland should be t and Mental	ic eve	To Be	Brock Dewitt							Gen	eva F	Pickett					
Shoul Mund Mind Mind Mind Mind Mind Mind Mind Mi	umati	-	19a. Informant's Name/Rela	ationship (7	Type. Print)		19b. N	lailing Add	ress (Street	and Numb	per or Ru	ıral Route Num	ber, City o	or Town, St	ate, Zip	Code)	
Ore, Marylan es 1 and 2 should be of Health and Mental fitem 27 is marked o	er tra		Lisa Ridgely/Da	ughter			1610	02 Ken	t Road	Laurel	Mary	yland 207	07				
Nore, iges 1 and tof He	r oth	ĺ	20a. Method of Disposition 1 X Burial 2 ☐ Crema	tion 2	Romoval from	Stato	20b. Place of D cemetery,	isposition ( crematory	Name of or other place	ce)		Date	20c. Lo	ocation - Ci	ty or To	wn, State	
IMOF Pages ment of ant: If its	o fun		4 □ Donation 5 □ Oth			State	lvy Hil	Ceme	tery	-	6/29/	/2007	La	urel, M	laryl	and	
Baltimo permit. Page Department of	any Inj once.		21. Signature of Fureral Se	rvice Licen	well.				e and Addre Funera		,	l Sandy S	pring	Road L	aure	1 MD 20	0707
* \$			23a. Part1. Enter the disea shock, or heart failure	se, or com	plications that o	caused the	death. Do not	enter the	mode of dyir	ng, such as	s cardiac	or respiratory	arrest,			Approxima Interval Be	te tween
Physic	cian		Immediate Cause (Final disease or condition	Liotomy			TED CONGE	STIVE	HEART F	A I LURI	E					Onset and	
/Med	_		resulting in death)		Due to	(or as a co	nsequence of)	;				,					
Exami			Sequentially list conditions,	2			TINAL BLE										
Pe	sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	~			onsequence of):		TCT LON	/ CED	CIC						
xecut	ıl-tran	хап	that initiated events resulting in death) Last		C		M DIFFICI		ECTION	/ SEP	313				-	-	
38760, icate be executed physician and	e buris	dical		l	RESP	RATOR	Y FAILURE										
68 tiffcat g phy		ledic		1965	· ·												
Hecords, P.O. Box of The law requires that the death certificate has been signed by the attending	shed for use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown  23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 5 □ Other (specify)							23d. Date of delivery Month Day Year		Year					
that the	detad		Part II. Other significant co	nditions o	ontributing to d	eath but no	ot resulting in th	ne underlyi	ng cause giv	en in Part	I.	23e. Did	tobacco	use contrib	ute to th	e cause of	death?
VITAL HECOLDS, sician: The law requires to certificate has been signer.	ed blu	d by										1	] Y <i>e</i> s 2	No 3	☐ Prob	ably 4 🗌	Unknown
SCOrd aw requir s been si	shor	olete										24a. Wa		24b. We	re autop	osy findings	available
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Ita	ctor, I	Be C	25. Was case referred to m	edical						26. Plac	e of Dea	ath (Check only					
hysic his ce	dire	2	1 ☐ Yes 2 No		Hospital: 1 X	Inpatient	2 ER/Outpa	atient 3	DOA Oth	er: 4□N	lursing H	lome 5□Re	sidence	6 □Other	(Specify	)	
Ing P	funeral	ü	27. Manner of Death 1 → Natural 5 → P	ending	,	of Injury oth, Day Ye	ea <i>r)</i> 28b. Tim Inju	ry	28c. Injur Wor	k?		28d. Describe	e how inju	ry occurred			
ISIO ttend death.	the f	cati	3 ☐ Suicide 6 ☐ C	vestigation ould not be		of injury -	At home, farm	M stroet fa		Yes 2	J No	20f Loostion	(Ctract as	ad Alumbar	or Burn	I Douglo Alum	
DIVISION OF tal or Attending Phy is after death. al Director; After this	filled in by the	Certification:	4 ☐ Homicide d	etermined	build	ing, etc. (S	Specify)	, 311661, 10	ciory, office			28f. Location City or T	own, State		or murai	r noute Nur.	nber,
Hos Fun	completely fill	ledical (			niner: On the b		ny knowledge, c amination and/c										s)
To the within 2 To the	СОШ	M	29b. Signature and Attle of o	) C	Jan	-1:	1		29c. Licens		74			te signed (			
27			30. Name and address of po	erson who	competed caus	se of death	(Item 23a) (Ty	pe, Print)	Suite 2	00 00	o lumb	ia. MD 21	-				
	Sta	te	31. Date filed (Month. Day.	Year)	32. F	Registrar's	Signature										
Re	gistr		1111	0 6 21	007   🗚	AC. 4 == =	15 1	Enal.	9								
DHMH 17 R	lev 1/20	001	JUL	- U V	14	CULT FOR	15 19	3/10									

**ORIGINAL** 

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death July 5, 2007 Month **Physician** Nancy Snowden Mary /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Timonium Stella Maris Nursing Center | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | April 2,1941 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2√2 F 66 218 36 3497 Director Usual Residence of Decedent 10c. City, Town or Location f show 10b. County ral", or items 23a or 28a-f shor Examiner must be notified at Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5004 Delagrange Avenue 21205 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 Never Married 2 Married 5-0036 1 ☐ Yes 2 🛣No Specify: 9 Specify: 3 ☐ Widowed 4 ☐ Divorced "natural" Completed permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natur any Injury or other traumatic event, the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Maryland 2121 Elementary/Secondary (0-12) College (1-4or 5+) Production Worker Spice Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John William Sunderland Matilda Dunn 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) (son) 1337 Riverside Avenue Essex Maryland 21221 Edward S. Snowden Jr Baltimore. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 □ Cremation 3 □ Removal from State Holly Hill Mem Gardens Jul 7, 2007 Baltimore County, Md 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Bruzdzinski Funeral Home PA 21. Stanature of Funeral Service License 1407 Old Eastern Avenue Essex Maryland 21221 complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. . El ter the disease, o , or heart failure. List Immediate Cause (Final disease of condition resulting in death) Adeno carcinomA, UN KNOWN BRIMARY **Physician** /Medical Due to (or as a consequence of): **Examiner** Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-transit and Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 💆 No 4□Pregnant at time of death 5 Other (specify) P.O. ed by the a 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an certificate has Yes Division or Vital funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE Hospital: 1 ☐ Yes 2 0 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred lospital or Attending P I hours after death. uneral Director: After t 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours at To the Funeral D Hospital

and manner stated

3. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0 6 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

1 ∏Yes 2 ☐ No

Maryland

USA

White

Black, White, etc.

Month

29d. Date signed (Month, Day, Year)

715107

Day

Year

4 Unknown

10:27 AM

DHMH 17 Rev 1/2001

Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifier

DR TARIQ

31. Date filed (Month, Day, Year)

Medical

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

\*\*Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

MAHMOOD 2300 Dulancy Valley Rd Timmium, Ml 21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician July 3, Frederick William Smith 2007 5:10 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F Director 213**-**03-2403 94 Sept. 14, 1912 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f shov must be notified at 1 ☐ Yes 2 XNo Director Maryland Harford Bel Air 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Apt. 115 21014 USA 555 South Atwood Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 May Yes 2 □ No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No Specify: þ 3 X Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 7 Is marked other than "natu traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Commercial Photographer Newspaper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဂ Frederick (unk) Smith Minnie (unk) (unk) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other tra P.O. Box 281, Glen Arm, MD 21057 Catherine Davis / Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 7-6-07 Glen Haven Cemetery Glen Burnie, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funetal Service Licenses 22 Name and Address of Facility
McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Priter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. MECHANICAL DISSOCIATION Immediate Cause (Final disease or condition resulting in death) LECTRO Physician /Medical Due to (or as a consequence of): Examiner ce quentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner SEVERE INSUFFICIENCE Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? þ 1 | Yes 2 | No 3 | Probably 4 | Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Comparison of the death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical

or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, 24 hours after death Funeral Director: within 2 X

"natural",

Registrar

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Dr. ANUSHA CIRITHARA

06

DHMH 17 Rev 1/2001

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

GATEWAY DRIVE,

29d. Date signed (Month, Day, Year)

SUITE 21/22B BELLIR, MD 21014

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar	e of Maryland	•	tificate of L		F	Reg. No U	07	21760
	Physici /Medic		Decedent's Name (First, Middle, Last)     Gopal S	ingh Sidhu	1			July 3		Year	3. Time of Death 10:20 P M
)	Examir		4a. Facility Name (If not institution, give street and 12204 Walnut Creek Cou	d number)		4b. City, Town, or Germante	Location of Death		4c. Count	y of Death	rv
	Funeral Director		5. Social Security Number 6. Sex 1 M 2	7. Age (In yrs. Ia	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Jan. 1,	n /, Year)	9. Birthp	lace (State or Foreign try)
	Maryland a-f show ified at	ctor	Usual Residence of Decedent  10a. State 10b. County  Maryland Montgomery	10c. City,	Town or Lo	cation rmantown	1.00 ptg			1	0d. Inside City Limits 1 ☐ Yes 2 🔀 No
	ath with the 23a or 28a ust be not	ral Director	10e. Street and Number 12204 Walnut Creek Co	urt		10f. Zip Code 208			10g. Citizen of India		
036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	1 Never Married 2 Married 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Decedent Ever in U.S ed Forces? Yes 2[X]No s, Give or Dates:		Vas Decedent of Hi f Yes, specify Cuba □ Yes 2 💢 No	ispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: Asian-Indian		
9500-5121	within 72 h iene. than "natu the Medical	Completed	15. Decedent's Education (Specify only highest grade completed in the complete state of	ege (1-4or 5+)	(Give life. L		ation during most of worki Officer	ng	16b. Kind of E		·
and 7	d be filed ental Hygi ked other c event, t	Be	17. Father's Name (First, Middle, Last) Sunder Singh Sidhu			- Walland	18. Mother's Name	(First, Middle, Kaur Gi	Maiden Surna		- 0200
, Maryland	and 2 should be faith and Mental I	To	19a. Informant's Name/Relationship (Type. Print Sukhdev Kaur Grewal/Da	ughter	12204	Walnut Cr	and Number or Rura eek Court				
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra		20a. Method of Disposition 1 ☐ Burial 2 颁Cremation 3 ☐ Removal 4 ☐ Donation 5 ☐ Other (Specify)	from State   20b. Pla ce Mon Crei	matori	sition (Name of natory or other plac Y um, Inc.	+ 20	5, 07	20c. Location Bethes	sda. N	Marvland
ga	permi Depar Impor any ir		21. Signature of Funeral Service Licensee	M0019	Rő 8 75	bert A. F 557 Wiscor	s of Facility Sumphrey I Sin Ave.,	Funeral Betheso	Home/ <sup>B</sup> da, MD 2	ethes Chas 0814 <b>-</b>	da-Chevy e Inc. 3501
	Physician /Medical Examiner			that caused the death. on each line.  Letastatic e to (or as a conseque	Rena1			or respiratory an	rest,		Approximate Interval Between Onset and Death
		niner	Sequentially list conditions, if any, leading to immediate cause. Liner Underlying Cause (Disease or injury that initiated events c.	e to (or as a conseque	ence of):						
ρα/ρη,	ifficate be executed g physician and as the burial-transit	edical Examiner	that initiated events resulting in death) Last	e to (or as a conseque	ence of):		_				-
O. Box b	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	sician/M	in the past 1 Z months?	s, outcome pf pregnan Live birth 2 ☐ Fetal or Pregnant at time of dea Unknown	death 3□	Ectopic pregnancy Other (specify)				ate of delive	ery Day Year
ecords, P	requires that een signed b oould be deta	ed by Phys	Part II. Other significant conditions contributing	to death but not result	ting in the ur	derlying cause give	en in Part I.	23e. Did to			e cause of death?
r	: The law re icate has be ; page 2 sho	Completed						24a. Was a autop perfor 1 Yes	sv	Were auto prior to cor death? 1 ☐ Yes	psy findings available npletion of cause of 2 ☐ No
VII	Physician: r this certific ral director,	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No  Hospital:	1 ☐ Inpatient 2 ☐ E	R/Outpatien	t 3 DOA Othe	26. Place of Death er: 4□ Nursing Ho			her (Snecifi	4
DIVISION OF	ath. ath. r: After thi		27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation		28b. Time of Injury	28c. Injury Work		28d. Describe h			,,
DIVIS	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined 28e. I	Place of injury - At hom building, etc. (Specify)	ne, farm, stre	eet, factory, office	4	28f. Location (S City or Tow	treet and Num n, State)	ber or Rura	l Route Number,
	the Hospi in 24 hou the Funer ppletely fill	Medical		o the best of my know the basis of examination manner stated.	rledge, death on and/or inv	estigation, in my o	pinion, death occurr	ed at the time,	date and place	, and due to	the cause(s)
	To To	Ž	29b. Signature and little of certifier	Ill		29c. License	D425 <b>7</b> 8	4	29d. Date signe July		*
	10			1119 Rockv	ille I	Pike #401	, Rockvil	le, Mar	yland	20852	2
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signatu	J. A	parti					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death . Decedent's Name (First, Middle, Last) Physician 0429 AM SHIFFLETT 2007 JUL /Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner BALTIMORE N/A JOHNS HOPKINS BAYVIEW MEDICAL CENTER 8. Date of Birth (Month, Day, Year) If Under 24 Hrs Birthplace (State or Foreign Country) **Funeral** 1√2 M 2 □ F Director 5,1921 223-24-4648 Dec. Virginia Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 ☑ No Director Baltimore Maryland Edgemere 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2403 Manning Avenue 21219 United States Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2]X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 21 No Specify: ģ 3X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Millwright Steel Industry 1 Year 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Susan Shifflett Daniel Shifflett ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Phyllis J. DiAngelo (Daughter) 735 Sea Wall Road Essex, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important; If ite
any Injury or ot
once. 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State Gdns. of Faith Cem. 7/5/2007 Baltimore, Maryland Donation 5 ☐ Other (Specify)

Physician /Medical

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

ms 23a or 28a-f show must be notified at

"natural"

if Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the M

**Examiner** 

21. Signature of Funeral Service Licensee

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

shock, or heart failure. List or	omplications that caused the death. Do not ally one cause on each line.			Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition	_a. RESPIRATORY	Failure		
resulting in death)	Due to (or as a consequence of):	Pro ( )		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. CONGESTIVE Due to (or as a consequence of).	Failure HEART Failure		
resulting in death) Last	c Due to (or as a consequence of):	10.00		
	d			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
Part II. Other significant condition	<b>s</b> contributing to death but not resulting in th	e underlying cause given in Part I.		use contribute to the cause of death?
			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No
25. Was case referred to medical examiner?		26. Place of De	ath (Check only one)	
1 ☐ Yes 2 ☐ ¥6	Hospital: 1 Impatient 2 ☐ ER/Outpa	tient 3 DOA Other: 4 Nursing I	dome 5 ☐ Residence	6 □Other (Specify)
27. Manner of Death  1 Natural 5 Pending 2 Accident investiga	28a. Date of Injury 28b. Tim (Month, Day Year) Inju	e of 28c. Injury at	28d. Describe how inj	
3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		street, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
	Physician: To the best of my knowledge, d kaminer: On the basis of examination and/o and manner stated.			
29b. Signature and title of certifier		29c. License number 7 1650 A 3 414		ate signed (Month, Day, Year)

22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

DHMH 17 Rev 1/2001

State

Registrar

SACHIN

31. Date filed (Month, Day, Year)

Eastern AVENUE

BALTIMORE, MD 21224

4940

32. Figistrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHRIDHARAW

0 6

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** Harmon В. Stone, 9:57 PM June 26, 2007 /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 2823 Wells Ave. Edgemere Baltimore Co. If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 → M 2 ☐ F Yrs. 81 Director 220-22-2524 Maryland June 11,1926 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 Yes 2 No Directo Edgemere Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be 2823 Wells Avenue United States 21219 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: WWII 1 ☐ Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify. 3 Widowed 4 Divorced Completed er than "natur t, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Grocery & Hardware Elementary/Secondary (0-12) College (1-4or 5+) Business Owner/Operator Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be Lucille Burkett Robert R. Stone ٩ traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Doris Stone Edgemere, Maryland 21219 (Wife) 2823 Wells Ave. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or o 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation , 5 ☐ Other (Specify) Uniontown Methodist Cem. 6/30/2007 Uniontown, MD 21. Signatur of uneral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part1. Enter the disease shock, or heart failure. L or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. Approximate Interval Between Onset and Death Immediate Caus disease or condi ion resulting in death) Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of) Examine The law requires that the death certificate be executed burial-transi Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the attending j IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 5 Other (specify) been signed by the should be detached 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I ģ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes → No 24a. Was an certificate has I autopsy perforn or Attending Physician: director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day Year) Natural 5 ☐ Pending investigation ours after death.

neral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a

To the Funeral I

completely filled To the Hospital

Registrar

31. Date filed (Month, Day, State

29b. Signature and title of certifier

29a. Certifier

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature Year)

and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEN THM/2 per HVS. THM/1 19 per INF. C69,7/19/07 WS
State of Maryland / Department of Health and Mental Hyglene 1 - For State Registrar Certificate of Death Reg. No: 2. Date of Death Month 24 1. Decedent's Name (First, Middle, Last) Day **Physician** 2007 11:40 AM June-Randolph Smithwick /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Brooklyn Park Genesis Hammonds Lane 8. Date of Birth (Month, Day, Year) Oct 23, 1926 9. Birthplace (State or Foreign Country) North Carolina If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1**∑**M 2□ F 80 Yrs. 228-20-9055 Director Usuel Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County or 28a-f show the Medical Examiner must be notified at 1√ Yes 2 No MD Baltimore Director 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 21225 USA 959 Stoll Street or Itame 23e death Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ሺ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) 11. Marital Status within 72 hours ofter 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: white Specify: þ 3 Widowed - Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry unk 15. Decedent's Education (Specify only highest grade completed) unk filed within Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 0 12 permit. Peges 1 and 2 should be filed v Department of Health and Mental Hygie Important: If Item 27 Is marked other I eny Injury or other traumatic event, ID 18 Mother's Name (First Middle Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Willie Jones Sam Smithwick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12478 Titus Cove Landing Carrollton, VA John Smithwick/s 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □Donation 5 Other (Specify) in State 21. Signatur of Fundantice Licensee Konald S. Wada State Anatomy Board 655 W. Baltimore Street mar 21201 Baltimore, MD 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Gause (Final disease or condition resulting in death) Munocardia Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physicien and for use as the burial-transit Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P. 0. ed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. ģ 3 ☐ Probably 4 ☐Unknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: al or Attending P s after death, I Director: After 1 Natural 5 Pending investigation 1□Yes 2□No 2 Accident the 3 🗌 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospitel or Atti within 24 hours after de To the Funerel Direct completely filled in by ti 4 Homicide 1 Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and vite of certifier D23465 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROAD Glen Burnie MD 21061 Mprojes

DHMH 17 Rev 1/2001

State

Registrar

Jude

31. Date filed (Month, Day, Year)

284L Obtmood

MD

0 6 2007

2. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar Mar

31. Date filed (Month, Day,

ORIGINAL

East For

Bue, Balkon

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

901

32-Registrar's Signature

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Physician 3:48 MARION DAVID THOMAS Ju1v 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Caroline <u>Caroline Home for Hospice</u> Denton Date of Birth (Month, Day, Year) 5. Social Security Number Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) Days Months 1 **™**M 2 □ F 219-28-6458 7/18/1931 TENNESSEE Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director CAROLINE **FEDERALSBURG** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 203 EAST CENTRAL AVENUE USA 21632 Funeral 14. Race -12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify. Specify. ģ 3 Widowed 4 □ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SPICE MANUFACTURING GROUNDS MAINTENANCE 4TH GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be DEWEY THOMAS ဨ LILLIAN UNAVAILABLE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) M. DAVID THOMAS, JR./SON 3809 WASHINGTON AVENUE ABINGDON, MD 21009 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 X Buria! 2 ☐ Cremation 3 ☐ Removal from State GARDENS OF FAITH CEM. 7/7/2007 PARKVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee THE JOHNSON FUNERAL HOME. P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 23a. 14-11. Enter the disease, or complications of the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a nsequence of): Sequentially list conditions, if any, leading to immediate cause. The Uniting Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 les 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe Yes 2 1100 edical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Hother (Specify) 1 | Inpatient 2 ER/Outpatient 3□ DOA 28b. Time of 28d. Describe how injury occurred

be executed burial-transi and Box 68760, physician the as attending use a for P.O. the 8 by 1 signed b Division or Vital Records, page 2 should Jas certificate l

To the Hospital or Attending

**Funeral** 

Director

28a-f show

Department of Health and Mental Hygiene. Important: for items 23a or Important: If item 27 is marked other than "natural", or items 23a or any Injury or other traumatic event, the Medical Examiner must be reany Injury or other traumatic event, the Medical Examiner must be reany Injury or other traumatic event, the Medical Examiner must be reany Injury or other traumatic event, the Medical Examiner must be reany Injury or other traumatic event, the Medical Examiner must be reany Injury or other traumatic event.

**Physician** /Medical

**Examiner** 

72 hours

Pages 1 and 2 should be

Baltimore, Maryland 21215-0036

notified

Examiner Physician/Medical þ Completed Be Certification: To After this funeral within 24 hours after death. To the Funeral Director; A

_		
25.	Was case reference?	erred to m
27.	Manner of De 1 Natural 2 Accident	ath 5 □ P in

3 ☐ Suicide

29a. Certifier

Medical

4 Homicide

ending vestigation 6 Could not be determined

28a. Date of Injury (Month, Day Year) Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Teal Drive, Suite 302, Easton, Maryland

1 Yes 2 No

Location (Street and Number or Rural Route Number, City or Town, State)

one) and manner stated. 29b. Signature an itle of certifier

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David Smith, N M.D., 31. Date filed (Month, Day, State 06

8221

Registrar's Signature

DHMH 17 Rev 1/2001

12

Registrar

	State of Maryland / De	partment of Health and Mental Hyg rertificate of Death	•
Physician /Medical	1. Decedent's Name (First, Middle, Last) Catherine Blackwell Tackney Talbott	July	1 2007 6:30 PM
Examiner Funeral	4a. Facility Name (If not institution, give street and number)  Joseph Richey Hospice  5. Social Security Number  6. Sex  7. Age (In yrs. last birthdom)  1	Months   Davs   Hours   Min.   (Month, Day	(, Year) Country)
Director show	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or	May 25,	1947 Rhode Island  10d. Inside City Limits 1 XYes 2 □ No
fter death with the Mar fter s2a or 28a-f si iner must be notified Funeral Director	Maryland N/A Baltin  10e. Street and Number  828 N. Eutaw St.		10g. Citizen of What Country? United States
urs after deat all, or items; Examiner mu by Funer	3 ☐ Widowed 4 X Divorced If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)     □ Yes 2 ☑ No Specify:	14. Race - American Indian, Black, White, etc.  Specify: white
Deficiel (1996) Interpretable A I A I 3-0030  permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+) 5+	ecedent's Usual Occupation live kind of work done during most of working e. DO NOT use retired) attorney	16b. Kind of Business/Industry 1ega1
yidilu, ould be filec I Mental Hyg narked othe natic event,	Stephen Noel Tackney	18. Mother's Name (First, Middle, Pricilla McLea	n Talbott
Fe, INGI	Mary J. Smith/executor 220  20a. Method of Disposition 20b. Place of Di	ailing Address (Street and Number or Rural Route Numbe 4 Westwood Rd. Annapolis sposition (Name of crematory or other place)  Date	
Dallillor permit. Pages Department of I Important: If Ite any injury or o once.	Burial 2 Micremation 3   Hemoval from State	1	Baltimore, Maryland
Physician	23a. Part. Enter the disease, or complications that caused the death. Do not strock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition)		rest, Approximate Interval Between Onset and Death
/Medical Examiner	Due to (or as a consequence of):		years
te be executed spician and be burial-transit	V.,		
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the Madical Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 W No 9 □ Unknown  23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)	23d. Date of delivery  Month Day Year
w requires that the been signed by should be detailed by Ph	Tate in Suiter significant containers contained by the resoluting in the	e underlying cause given in Part I. 23e. Did to	obacco use contribute to the cause of death?  Ves 2 Probably 4 Unknown
in The law required to the			prior to completion of cause of death?  1 Yes 2 No
sion of vital trending Physician: 1 leath. tor: After this certificat the funeral director, p	1 Yes 2 No nospital: 1 Inpatient 2 ER/Outpa	e of 28c. Injury at 28d. Describe h	
tral or Attending F rs after death. ral Director: After ied in by the funer. Certification:	3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, building, etc. (Specify)	City or Ton	
the Hospi thin 24 hou the Funer ompletely fill	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, described only one)  2 Medical Examiner: On the basis of examination and/cone and manner stated.	or investigation, in my opinion, death occurred at the time,	date and place, and due to the cause(s)
	30. Name and address of person who completed cause of death (Item 23a) (Ty	D24170	July 2, 2007
\S tate	31. Date filed (Month, Day, Year)  Richer Hospice 838  32. Registrar's Signature	N. Eutaw St. Baltimor	re, MD 21201
Registrar	JUL 0 6 2007 Januar 15.	gova	

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day Month DONALD ISAAC THOMAS 23:10 JUNE 27 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE-WASHINGTON MEDICAL CENTER GLEN BURNIE ANNE ARUNDEL 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Months Days Hours 9 4 2 3 7 1 9 4 3 **1**√2 M 2 □ F WASHINGTON, DC 216-48-8694 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits MD ANNE ARUNDEL GLEN BURNIE 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 213 ROYAL ARMS USA 21061 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 2X If Yes, Give Year or Dates: 1 ☐ Yes 🌠 ☐ No Specify: Specify: BLACK 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) BOWIE STATE Elementary/Secondary (0-12) College (1-4or 5+) UNIVERSITY (MD) MAINTENANCE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) CHARLES THOMAS SARAH JACKSON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GAYE BANKS / NIECE 213 ROYAL ARMS WAY, GLEN BURNIE, MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) LINCOLN CEMETERY 7/3/07 BRENTWOOD, MD 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AVE, BALTIMORE, 23a. Part 1 cher the dispase, or complications that caused the death shock, or beart failure. List only one cause on each line. o not enter the mode of dying, such as cardiac or respiratory arrest, use (Final minutes disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? 2 No 1 Yes 2 🗆 No 25. Was case examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical Examiner

Examiner

Physician/Medical

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Completed

Be

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Certification:

Medical

27. Manner of Death

1 Matural

2 ☐ Accident

3☐ Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

29b. Signature and title of certifier

permit. Pages 1 and 2: Department of Health a Important: if item 27 Is any injury or other trauonce.

Physician

/Medical

Examiner

Director

Funeral

δ

Completed

Be

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12

**Funeral** 

Director

show

ortant: If item 27 is marked other than "natural", or items 23a or 28a-f si injury or other traumatic event, the Medical Examiner must be notified

Baltimore, Maryland 21215-0036

be executed the burial-trar attending physician for use as the buria the detached by signed by the sign of the sign

Box 68760.

page 2 should has

P.O. Division or Vital Records, certificate this After t Hospital or Attending n 24 hours after death.

ne Funeral Director: Af
pletely filled in by the fur within 24

DHMH 17 Rev 1/2001

State Registrar

29c. License number

MC Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

026199

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Enclus a Dimer MD 2191 Defense Hwy, Svite 201, Crofton MD

28b. Time of

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

3 Registrar's Signature

28a. Date of Injury (Month, Day Year)

5 Pending

investigation

6 Could not be determined

Antonio tracey
07-05072 Ple

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

NK UNK	1- For State	partment of Health and Mental H <i>Pertificate of Death</i>	ygiene Reg. No. 2017 217 6						
Physician Medical Examine			2. Date of Death 3. Time of Death Month Day Year 2353 here						
reultai Examine	4a. Facility Name (if not Institution, give street and number)	4b. City, Town, or Location of Death	July 2, 2007						
Funnal	John Hopkins Hospital  5. Social Security Number 6. Sex 7. Age (In yr.	Baltimore s. last birthday) If Under 1 Year If Under 24Hrs	s. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or						
Funeral Director	UNK	31 Yrs. Months Days Hours Min	Transita						
a was a second of the	Usual Residence of Decedent 10a. State 10b. County 10c, C	City, Town or Location	10d. Inside City Limits						
M	MD N/A	BALTIMORE	1 XYes 2 No						
72 hours after death with the Maryland n"natural", or items 23a or 28a-f sho ral Earniner must be notified at once	10e. Street and Number 1125 ELLICOTT DRIVEWAY	10f. Zip Code 21216	10g. Citizen of What Country?  USA						
or items 23s	11. Marital Status 1 X Never Married 2 Married Armed Forces?	If Yes, specify Cuban, Mexican, Puerto							
after de al", or i	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2 X No specify:	Specify: BLACK						
2 hours al		) 16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use ret							
5-0036 led within 72 hours al Hygiene. other than "natural the Medical Examin	11	AUTOMECHANIC PAINT							
21215-0036 Muld be filed within 7 Mental Hygiene. marked other than ic event, the Medica			e (First, Middle, Maiden Surname) BUTLER						
O & S is is in	19a. Informant's Name/Relationship (Type, Print ) SHARON BUTLER / AUNT		Rural Route Number, City or Town, State, Zip Code) BALTIMORE, MD 21218						
ore, ME	1 Percent 2 Cremation 3 Removal from State	bb. Place of Disposition (Name of cemetery, crematory or other place)	Date 20c. Location - City or Town, State						
Baltimore, permit Pages I an Department of Her Important: If ite injury or other tr	4 Donation 5 Other Specify:  21. Signature of Funeral Service Licensee	MT. ZION CEMETERY 7/							
Bal permi Depar Impo injur	(Chillian / B Rown	14600 LIBERTY HE	WELL FUNERAL HOME 21207 IGHTS AV, BALTIMORE, MD						
Physician /Medical	23 Learn. Enter the disease, or complications that caused the of failure. List only one cause on each line.	ath. Do not enter the mode of dying, such as cardiac	or respiratory arrest, shock, or heart Approximate Interval Between Onset and Death						
aminer	Implediate Cause (Final disease or Indition resulting in death)  a. Multiple Gunshot Wo								
	Sequentially list conditions, if any, leading to immediate	e of):	M A Y.						
ted nisit	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last    C. Due to (or as a consequence)								
	d. UNPENDED AMENDED								
ficate be ex g physician the burial	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pi		23d. Date of delivery ancy Month Day Year						
tion of Vital Records, P.O. Box 6876( trending Physician: The law requires that the death certificate teath. ttor: After this certificate has been signed by the attending phy- the funeral director, page 2 should be detached for use as the better the Corporation of the control	past 12 months?  4 Pregnant at time of	2	ancy Month Day Year						
O. B. at the de lby the lached f		ot resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?						
ords, P.O. w requires that the second			1 Yes 2 No 3 Probably 4 Unknown						
of Vital Records, mg Physician: The law requind the this certificate has been somethed firector, page 2 should the Transcal of Commission of the Commission			24a. Was an autopsy autopsy performed?  24b. Were autopsy findings available prior to completion of cause of death?						
Vital Rec ysician: The his certificate director, page	25. Was case referred to medical	26.Place of Death (Check	1 ✓ Yes 2 No 1 ✓ Yes 2 No only one)						
f Vita Physicia r this ce al direc	examiner? 1 Ves 2 No Hospital: 1 Inpatient 2		ng Home 5 Residence 6 Other:						
ion of tending Pheath. tor: After the funeral	27. Manner of Death  1 Natural 5 Pending FO(M), Day, Year)  28a. Date of Injury FO(M), Day, Year) Jul 2, 2007	28b. Time of Injury FOUND: 2327 hrs  28c. Injury at Work?  1 Yes 2 ✔ No	28d. Describe how injury occurred Subject shot						
Division o  To the Hospital or Attending within 24 hours after death. To the Funeral Director: Aft completely filled in by the funeral	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) Local St	At home, farm, street, factory, office building, etc.	28f. Location (Street and Number or Rural Route Number, City or Town, State) 1100 Greenmount Avenue, Baltimore, Md.						
& 2 a a a a a a	20a Certifier	ledge, death occurred at the time, date and place, and	due to the cause(s) and manner as stated.						
To the Ho within 24 To the Fu completel	one) 2 Medical Examiner: On the basis of examinatio and manner stated.  29b. Signature and title of certifier	an and/or investigation, in my opinion, death occurred  29c. License number	at the time, date and place, and due to the cause(s)  29d. Date signed (Month, Day, Year)						
	Chi de HA e O a	O.C.M.E.	July 3, 2007						
Y	30. Name and address of person who completed cause of death (If Carol Allan, MD Assistant Medical Examiner	30. Name and address of person who completed cause of death (Item 23a)  Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201							
Stat	31. Date filed (Month, Day, Year) 32. Registrar's Sign	31. Date filed (Month, Day, Year)  32. Registrar's Signature							
Registra	11 JUL 0 6 2007 Beaucon	S. Goode							

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Physiciar Medical Examin	1/	legistrar 1. Decedent's Name (First, Middle,Last) Amanda T	aylor							Date of Death Month June 29, 2	n Dav	Year	3. Time of Death 0003 hrs
}		4a. Facility Name (if not institution, give s Cumberland Memorial Hosp	treet and number	)		4b. City, Tov		ocation of			4c. Co	unty of Death	
Funeral	-	5. Social Security Number 6. Sex		je (In yrs. la	ast birthday)	If Under		If Under :	24Hrs.	. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or			hplace (State or
Director			1 2 X F	44	Yrs	Months 5.	Days	Hours	Min.	Sept.	ot.4,1962 Foreign Maryland		
any		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Locat	ion				· · · · · · · · · · · · · · · · · · ·	140		10d. Inside City Limits
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Maryland 28a-f show d at once.	Director	10e. Street and Number				10f. Zip C				10	-	of What,Cou	ntry?
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after de ner mi	by Ft	3 Widowed 4 Divorced	Yes, Give Yeer	X No	1	Yes 2 X	Νο	specify:			Spe	ecify: Wh	ite
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ore, ses 1 an of Hea If iter		20a. Method of Disposition  1 X Burial 2 Cremation 3	Removal from S	into (	Place of Dispos crematory or of	her place)				Date		ation - City or	
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Ba perm Depa Impo injur	1	The	-										d 21222
Physician /Medical		23a. Part I. Enter the lease, or complic failure. List on one cause on each	ations that caused line.	the death	. Do not enter t	the mode of	dying, s	uch as car	diac or r	espiratory arre	est, shock,	or heart	Approximate Interval Between Onset and
raminer	İ	Immediate Cause (Final disease a(	hronic and	d acute	e aspirat	ion pne	eumon	ia					Death
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760, icate be physic the bur	ĕ ا≩	IF FEMALE: 3b. Was decedent pregnant in the	23c. If yes, outco		nancy			-				ate of deliver	
Box 68760, e death certificate be the attending physici ad for use as the buri	cian	past 12 months?	1 Live birth 4 Pregnant a	t time of de	oth =	etal death ther <i>(Specif</i> i	3 <u> </u>	Ectopic p	oregnand	У	Мо	nth	Day Year
BO) he deatl the att	hysi	1 Yes 2 No 9 V Unknown	g Unknown					and the David		20a Didda	<b>.</b>	a a a tei buta ta	the cause of death?
i, P.O. B ires that the d signed by the I be detached	2	Part II. Other significant conditions of Cornelia DeLange sy	•		-		ause giv	ven in Part	l.		2 V N	,	pably 4 Unknown
rds, require been si	eted	Pulmonary thromboo								24a. Was a			itopsy findings available
Division of Vital Records, P.O. rat or Attending Physician: The law requires that it is after death.  "In Director: After this certificate has been signed by the funeral director, page 2 should be detactive.	Completed by									autop perfor	med?	death?	
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f Vit	의	1 Yes 2 No		ent 2	ER/Outpatien 28b. Time of			other 4 at Work?		Home 5 8d. Describe h	Residence		r:
on of \ anding Ph. ath. r: After tl he funeral	Ë	1 Natural 5 Pending	28a. Date of Inj (Month, Day, 4/11/200)		4:00 pm			es 2 X		subject o			l bolus
ViSic or Atte fler des Directo	Certification:	2 X Accident Investigation 3 Suicide 6 Could not be	28e Place of I		. A		ffice bu	ilding, etc.			Street and I		ıral Route Number, City
Dji spital hours a neral l	ਰ ਹੈ -	4 Homicide determined	(Specify)	-	spital					9000 Fran	nklin S		Baltimore, MD
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn	Medical	(Check only one) 2 Medical Examiner: C	on the basis of exa										
To With	ĕŀ	29b. Signature and title of certifier	nd manner stated		_	29c. I	License	number		· · · · · · · · · · · · · · · · · · ·	29d. Date	e signed (Mo	nth, Day, Year)
		Patricilaron	nie-	Hoe	De us	.   '	O.C.N	1.E.			June 3	30, 2007	
		30. Name and address of person who co Patricia Aronica-Pollak MD.	mpleted cause of Assistant	,		111 Per	n Str	eet Ralt	imore	MD 2120	1		
Sta	te	31. Date filed (Month, Day, Year)	32 Registr			,,,,,		oot, Dall		2 120	•		
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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			riease	State of Maryland / Depart				
			For State		rtificate of Death	Reg.	/ 1111 /	21771
			Registrar  1. Decedent's Name (First, Middle, Last		timodio oi bodii.	2. Date of Death		3. Time of Death
	Physicia		Edna	a May V	asold	July 2,	Day Year 2007	2:15 A <sup>M</sup>
	/Medic		4a. Facility Name (If not institution, give		4b. City, Town, or Location of Death		4c. County of Death	
	il jako	× 150	Summit Park Nu	arsing Home	Catonsville		Baltimor	
	Funeral		Social Security Number     6. Se	T.,	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Ye		place (State or Foreign ntry)
, ş	Director		212-10-2491 Usual Residence of Decedent	91 Yrs.		April 30	,1916 Ma	ryland
	land ow		10a. State 10b. County	10c. City, Town or Lo	ocation			10d. Inside City Limits
	Mary	ţō	Maryland Bal	timore	Catonsville	ے		1 ☐ Yes 2% No
	or 28e	Director	10e. Street and Number	CIMOLO	10f. Zip Code		Citizen of What Cou	ntry?
	th wit		912 South Roll		21228		United St	
	r dea	Funeral	11. Marital Status		Was Decedent of Hispanic Origin? (Sp. 1f Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
36	s afte	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1  Yes 2  No If Yes, Give Year or Dates:	1 ☐ Yes 21 No Specify:		Specify:	White
Maryland 21215-0036	within 72 hours after death with the Maryland ane. then "neturel" or iteme 23e or 28e-t ehow he Madical Exemirer mat be multical at	edt	15. Decedent's Ed	lucation 16a. Dece	dent's Usual Occupation		. Kind of Business/In	
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yla	12 should be filed w n and Mental Hygian ris marked other ti raumatic event, III	၉				Rose	·	- 0- 4-1
Nar	iges 1 and 2 should be filed within 72 hours after death with the Marylan to Health and Mental Hygiane. If item 27 is marked other than "natural", or iteme 23a or 28a-1 show or other traumatic event, the Madical Examinar and ke inclined at		19a, Informant's Name/Relationship (7		ing Address (Street and Number or Ru			
	1 and 2 Health tem 27 i		Mr. Thomas E. Vas 20a. Method of Disposition	20b. Place of Dispo	osition (Name of	timore, Ma	aryLand 2 c. Location - City or T	11228 own, State
20	permit. Pages Department of t Important: if ite any injury or of		1 ☑Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Memoval from State	matory or other place)  1. Cemetery		Baltimore,	Marvland
Baltimore,	permit. Pa Departmer Important: any injury	1	21. Signatur of uneral Service Licen	^	2. Name and Address of Facility	/2007	,	210.27
Ba	Depa Impo any in		Essedon E		ouda-Ruck Funeral 922 Wise Ave. Du	Home of Du	indalk, In	222
**	19.48		23a. Part1. Enter the sease, o comp	plications that caused the death. Do not en one cause on each line.	ter the mode of dying, such as cardiac	or respiratory arrest,	7	Approximate Interval Between
H	Physician		Immediate Cause (Final disease or condition	Cerebral Th				Onset and Death
**	/Medical		resulting in death)	Due to (or as a consequence of):				
367	Examiner	L	Sequentially list conditions,	b. Due to (or as a consequence of):				
	ed isit	lne	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):				
_	sician and burial-transit	Examiner	that initiated events resulting in death) Last	c				
760,	e be e /siciar e buria	caiE		d				
9		ledic						
Box	death certificat e attending phy id for use as th	M/us	230. was decedent pregnant	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3	□Ectopic pregnancy		23d. Date of deliv	rery Day Year
O.	0 00 9	sicis	in the past 12 months? 1 ☐ Yes 2 ☐ No		Other (specify)		MOITH	Day 16a1
<u>Р</u>	ac oc	Physician/Medi	9 Unknown	ontributing to death but not resulting in the u	underlying cause given in Part I	23e. Did tobac	co use contribute to	the cause of death?
	w requires that s been signed to should be det	by	Part II. Other significant conditions of	Stributing to death out not resoning in the	anderlying cause given in Fart.			bably 4 Unknown
Sor	v requ been shoul	Completed				24a. Was an	24b. Were aut	opsy findings available
Rec	The lay	dmo				autopsy performe	d? prior to co	ompletion of cause of
ta		e Co	25. Was case referred to medical		26 Place of Dea	1 ☐ Yes 2 ☐ ath (Check only one)	No 1 ☐ Yes	2 NO
of Vital Records,		To B	examiner?	Hospital: 1 Inpatient 2 ER/Outpatie	Other	lome 5 Residence	e 6 Other (Spec	ify)
0	ng Physiter this		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury 28b. Time of Injury Injury	of 28c. Injury at Work?	28d. Describe how	injury occurred	
Siol	Attending in death.  ector: After by the fune	catic	2 Accident investigation		M 1 Yes 2 No			
Division	or Att	ertification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, st building, etc. (Specify)	treet, factory, office	City or Town, S	et and Number or Rui State)	rai Houte Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	O	29a. Certifier 1 Certifying Ph	ysician: To the best of my knowledge, dea	th occurred at the time, date and place	and due to the caus	se(s) and manner as	stated.
	24 hd Fun etely	edical	(Check only 2 Medical Examone)	niner: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occu	rred at the time, date	and place, and due	to the cause(s)
	To the within 2. To the complet	₹	29b. Signature and title of certifier		29c. License number	29d	. Date signed (Month	, Day, Year)
			Vosty 20		DOU5333?		7-2-07	
	K		1	completed cause of death (Item 23a) (Type				
	9		110	trenue Suite 263		21209		
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's Signature	Est .			
	**************************************	3.6 %	1111 0 6 2007	MERLINE NO POPULA				

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year ac Physician 2007 W00 DS June AMES /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 944 Baltimore
If Under 1 Year | If Under 24 Hrs. Harlem Ave Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1**⋈**M 2□ F 377-38-5486 Yrs. 80 June 4, 1939 South Carolina Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location r than "natural", or iteme 23s or 28s-f show the Medical Examinar must be notified at 1 XYes 2 □ No Maryland N/A Directo Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21201 944 Harlem Ave USA filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: American Indian þ 3 ☐ Widowed 4 ☑ ivorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Etementary/Secondary (0-12) College (1-4or 5+) Construction Worker Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) it. Pages 1 and 2 should be introduct of Heelth and Mental Unknown Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Niece 944 Harlem Ave. Baltimore MD Lisa Coles 21201 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Anatomy Gifts Registry June 29,2007 Hanover, MD 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Anatomy Gifts Registry 21. Signature of Funeral Service Licensee 7522 Connelley Drive Soite P. Hanover, MD 21076 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. tmmediate Cause (Final disease or condition resulting in death) Physician hepalic CARCINOMA /Medical Due to or as a consequence of) Examiner Sequentially list conditions, if any, leading to infine-diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physicien for use as the buria Physician/Medicai the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 1 ☐ Yes 2 ☐ No 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death | Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ۵ 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Certification: 27. Manner of Death 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation М 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier (Check only one) 29b. Signature and title of certifier 15872 July 2, 2007 terstown Maryland 21136 30. Name and address of person who completed cause of death (ttem 23a) (Type, Print) MAIN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUL 0 6 2007

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 07:15 AM 02 2007 JULY WILLIAMS DAVID /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner HOSPITAL BALTIMORE CITY HOPKINS THE JOHNS If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 2-6-1939) 9 Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 11XM 2□ F N.C. 68 Director 723-01-4198 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-4 ehm... any injury or other traumatic event, the Medical Europea. 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 X Yes 2 No Baltimore MD N/A Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21218 2007 Robb Street Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XXNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Black 1 ☐ Yes 2 X No Specify: Specify. ģ 3 ☐ Widowed 4 ☑ Divorced 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Mass Transit Admin Elementary/Secondary (0-12) College (1-4or 5+) Bus Operator 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be Mary A. Fountain Clarence E. Fountain ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Danette Williams-Daughter Baltimore, MD 21218 2007 Robb Street 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Randallstown, MD King Memorial Park 7-7-2007 4 Donation 5 Other (Specify) March F/H West 22. Name and Address of Facility Signature of Funeral Service Licensee mal Wabash Avenue Balto, Md 21215 4300 23a. P. 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, s tock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final dise) se or condition resulting in death) YEARS Physician PAILURE CONGESTIVE HEART /Medical Due to (or as a consequence of): Examiner 10 YEARS DISEASE ARTERY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CORONARY Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of) ed by the attending physiclan detached for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy

1 ☐ Live birth 2 ☐ Fetal death

4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No certificete has page 2 s 1 ☐ Yes 2 ☐ No 1 | Yes Physician: Atter this certific funeral director, 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospital: 1 Inpatient Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA ၉ this 28d. Describe how injury occurred 28b. Time of 28a. Date of Injury 28c. Injury at Work? 27. Manner of Death Certification: (Month, Day Year) Attending Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death the 1 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide ō within 24 hours af

To the Funeral D

completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29c. License number 29b. Signature and title of certifier

DHMH 17 Rev 1/2001

P.0.

or Vital Records,

Division

State Registrar

31. Date filed (Month, Day, Year) 06

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ca

MAJMURAL, JOHNS HOPKINS HOSPITAL, GOO NORTH WOLFE STREET 32. Registrar's Signature

MEDICAL DOCTOR

**ORIGINAL** 

RES- 000

2007

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

			State of Maryland / Department of Health and N State Registrar  State of Maryland / Department of Health and N Certificate of Death	nental Hy	/giene Reg. No	007	21774
	Physici		1. Decedent's Name (First, Middle, Last)  Ribert Williams	2. Date of Do Month	eath Day 7	Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death		-	unty of Death	
			Anne Arundel Medical Center Annapolis		Ann	e Arun	del
	Funeral Director		5. Social Security Number 6. Sex 1. A security Number 031-18-0058 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Bi	av. Year)	Coui	place (State or Foreign htry) achusetts
			Usual Residence of Decedent	Mal. Z	0, 192	o mass	achusetts
	anylar show	7	10a. State 10b. County 10c. City, Town or Location			1	1 ☐ Yes 2 ☒ No
	the M 28e-f	Director	Maryland   Anne Arundel   Edgewater   100. Zip Code		10a. Citizer	of What Cou	
	h with 23a or 81 by	al Di	3608 Branhum Road 21037		U.S.A		,
	r deal	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Amed Forces?  13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No Rican, etc.)		Race - Americ Black, White,	
36	irs afte	by F	1 ☐ Never Married 2 ☐ Married 1 M Yes 2 ☐ No If Yes, Give 1 ☐ Yes 2 M No Specify: Year or Dates:			ecify: Whi	
21215-0036	72 hou neture lical E		15. Decedent's Education 16a. Decedent's Usual Occupation	ring	16b. Kind	of Business/In	
121	within ine.	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+) 4  Give kind of work done during most of work life. DO NOT use retired)  Pharmaceutical	ang	Consu	1+25+	
q 7	filed v Hygie other t		17. Father's Name (First, Middle, Last)  18. Mother's Name	e (First, Middle			
/lan	uld be Mental rked c	To Be	Samuel Williams Louise I	Locke			
Maryland	s 1 and 2 should be filed within 72 hours after death with the Maryland Fleath and Mental Hygiene. Itam 27 is marked other then "netural", or Itams 23a or 28e-f show other traumatic avent, the Medical Exert for must be notified at		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rur				Code)
	1 and Health Iam 27		Martha Stewart (Daughter) 3608 Branhum Rd., Edgev  20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)	vater, ]		37 on - City or To	own. State
IO E	Pages nent of A int: if its iry or o		1 \( \text{Burial} \) 2 \( \text{Cremation} \) 3 \( \text{Removal from State} \) \( \text{North Cemetery} \) \( \text{6/29} \)	/07		ridge,	
Baltimore,	permit. Pages 1 al Department of Hea Important: if itam any injury or othe		21. Signalure of Fineral Service License 22. Name and Address of Facility Belanger Bullard Fu	neral	Home		
			23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac	nbridge or respiratory a	MA ()	1550	Approximate
	Physician		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a	weon	ally	ni I	Interval Between Onset and Death
	/Medical Examiner		resulting in death)  Due to (or a la consequence of):				
	Examine.	e.	Sequentially list conditions, if any, leading to inmediate b. Due to (or as a consequence oi):			-	
ND.	cuted	Examine	Sequentially list conditions, if any, reading to infinediate cause. Einer Underlying Cause (Disease or injury that initiated events c.				
50,	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Ex	resulting in death) Last Due to (or as a consequence of):				
UE 68760,	ficate by physical ph	edlcal	d				
C X	death certifica attending ph d for use as th	In/Me	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy		23d	Date of delive	ery
). B	it the deat by the attr tached for	Physiclan/Med	in the past 12 months?  1 Yes 2 No 4 Pregnant at time of death 5 Other (specify) 9 Unknown			Month	Day Year
9.P.	res that thighed by		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did	tobacco use	contribute to the	ne cause of death?
rds	w requires been sign should be	ed by	A pleural effusion	10	Yes 2□N	o 3 🗆 Prob	ably 4 Unknown
) (S	law requ as been 2 shouk	Completed	I wan in Suppliering alcohol sider	24a. Was		4b. Were auto	psy findings available mpletion of cause of
Z E		Con		perfo	ormed? 2/3 No	death?	2 No
Vital	Physician: The this certificate ral director, pag	o Be	25. Was case referred to medical examiner?  1  Yes 2 No			Other (Consider	.1
350		on: To		28d. Describe			//
the	tent leath tor: the	catic	2 Accident investigation M 1 Yes 2 No				
Divisi	spital or Attendous after deathous after deathous haral Diractor:	Certification:	3 Suicide determined determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		Street and N wn, State)	umber or Rura	i Route Number,
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	edical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner stated.	and due to the red at the time,	cause(s) and date and pla	d manner as si ce, and due to	ated. the cause(s)
	To th within To thi	Me	29b. Signature and title of certifier 29c. License number		29d. Date si	gned (Month,	Day, Year)
			Attitud Stewarm D21438		gu	nu V	0,2007
1	10		30. Nam- and address of pers, o completed cause of death (Item 23a) (Type, Print)  MICHAREL SCALEN TO WM 44 DEFONSO HIGHWAY A	NNAPO	us IM	1 V14	o i
	Sta Registra		31. Date filed (Month, Day, Year)  32. Registrar's Signature  JUL 0 6 2007				
			The state of the s		_		

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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		_	For State Registrar		Cei	rtificate of			Reg. No.	07	21775
F.	Physici	an 4	Decedent's Name (First, Middle		e R. Willia	ame		2. Date of De Month	Day Jul 1, 200	Year	3. Time of Death  11:30 p M
1	/Medic Examin		4a. Facility Name (If not institution		C IV. AAIBIIG		or Location of Death	1	4c. County		то р
f :	LAdiiiii	3	M	Iford Manor Nursing	Home		Bal	timore		N	I/A
	Funeral Director		5. Social Security Number <b>246-38-6646</b>		(In yrs. last birthday) 80 Yrs.	If Under 1 Year Months Days		(Month, Da	th ly, Year) 17, 1927	Cour	place (State or Foreign ntry) o. Carolina
	and w	-	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	cation				1	10d. Inside City Limits
	Maryl -f sho	ţō	Maryland	N/A			Baltimore				1 ☐ Yes 2 ☐ No
	th the	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Cour	itry?
	23a c	Tal [	3119 Greenmead F				21244			U.S.	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Marr  3 ☒️Widowed 4 ☐ Divorced	ied 12. Was Decedent Examed Forces?  1 ☐ Yes, Give Year or Dates:	)	Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 📆	Hispanic Origin? (S ban, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	Specif	ce - Americ ck, White,	
9	72 hou natura Ilcal E	ted	15. Deceden (Specify only higher	t's Education	16a. Dece	dent's Usual Occu	upation e during most of wor	rkina	16b. Kind of B	usiness/Ind	dustry
21215-0036	ithin 7 ne. nan "r	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	life.	DO NOT use retir	ed)	nung	ב	anko A	Arlington
121	e filed w ai Hygler other th		17. Father's Name (First, Middle,	l act)			Foundry  18. Mother's Nan	ne (First Middle	Maiden Surna	ne)	
anc	d be f ental h ed ot	Be	•	ırtis Williams			To: Would S Hall		nnie Willia		
Maryland	should ind Men marke umatic	2	19a. Informant's Name/Relations		19b. Mailii	ng Address (Stree	et and Number or Ru	ıral Route Numb	er, City or Town	, State, Zip	Code)
	1 and 2 s Health ar tem 27 is		Angela B. Smith		3	3119 Greenr	nead Road Ba	altimore , Ma	aryland 212	44	
Baltimore,	Pages 1 and the properties of		20a. Method of Disposition  1    Cremation  4 □ Donation 5 □ Other (S		1	sition (Name of matory or other pl	i	Date 07/05/07	20c. Location	- City or To B <b>altimo</b> r	<i>'</i>
Balti	permit. Departm Importa any Inju		21. Signature of Funeral Syrvice	(1.95)	101	2. Name and Add Estep 1300	Brothers Fun	eral Service Baltimore, N	e, P. A. Md 21217		
	Physician /Medical Examiner	iner	23a. Part1. Enter the disease or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, and the shock of the cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	consequence of:	ar the mode of dy	ving, such as cardiac	c or respiratory a	rrest,		Approximate Interval Between Opset and Death
.O. Box 68760, 🧒	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physician/Medical Examiner	that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9  Unknown	c	Pretal death 3 ☐	□Ectopic pregnan □ Other ( <i>specify</i> )	icy		1	ate of delive	ery Day Year
Ω.	w requires that th s been signed by t should be detach	þ	Part II. Other significant condition	ons contributing to death but  The state of the state of		nderlying cause g	iven in Part I.			tribute to the	he cause of death?
al Records,	The la ate has page 2	Completed		10000				24a. Was auto perfo 1∐ Yes		prior to co death?	opsy findings available impletion of cause of 2□ No
Zi.	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medica examiner?	Hospital:			26. Place of Dea				
ō	Physer this eral di	2	1 ☐ Yes 2 ☐ No  27. Manner of Death	28a. Date of Injury	28b. Time o	IL 3 DOA	44 Nursing H	lome 5 Resi	dence 6 ∐Ot how injury occu		ý)
ion	Attending r death, ector: After by the fune	tior	1 Natural 5 □ Pendin 2 □ Accident investi		Year) Injury		ork? ⊒Yes 2.⊒No				
Division or Vital	i gitte	Certification:	3 ☐ Suicide 6 ☐ Could determ		y - At home, farm, sti (Specify)	reet, factory, office	е		Street and Num wn, State)	ber or Rura	al Route Number,
	he Hospital in 24 hours a he Funeral pletely filled	Medical (		ng Physician: To the best of Examiner: On the basis of and manner stat	examination and/or in						
	To the within 2 To the comple	Ž	29b. Signature and title of contine	MI	0	29c. Licer	127569		29d. Date signe	ed (Month,	Day, Year)
	1		30. Name and address of person	lett Ceman	183	Print)	27569 ieene 7	ree	Rd	211	L 08
	Sta		31. Date filed (Month, Day, Year)	6 2007 32. Registral	rs Signature	Cooks					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 18 per inf (869 7-19-07 vt State of Maryland (Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year ISELOTTE WOOD 12:15 AM 01 2007 07 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BAYVIEW MEDICAL TOHNS HOPKINS CENTER BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 💢 F 215-80-8464 Director 88 June 18. 1919 Gennany Usual Residence of Decedent the Maryland 10b, County 10c. City, Town or Location 10d. inside City Limits 28a-f show notified Maryland 1 ☐ Yes 2X No Baltimore County Director Packville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or , iner must b 8810 Walther Blvd, #3318 Funeral 21234 Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 14. Race 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 6 altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ Specify: 3 ☐ Widowed 4 ☐ Divorced White 'natural', Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) r than College (1-4or 5+) Homenakec Own Residence 7 Is marked other traumatic event, t 18 Mother's Name (First, Middle, Maiden Surname) Hundertmark 17. Father's Name (First, Middle, Last) Be Karl Willy Meinhardt 2 <del>Johanna</del> Heonine Auguste <del>Hunteonack</del> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Barbara A. Nolan (Daughter) 1610 Landon Road, Towson, Maryland 21204 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of I Important: If It any Injury or o 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Green Mount Crematory 7/3/2007 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Fune al Service Report An Marcin D. Lawson 22. Name and Address of Facility MITCHELL-WIEDEFELD FUNERAL HOME, INC. Parcin D. Lawson 6500 York Road, Baltimore, Maryland 21212

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximately a such as cardiac or respiratory arrest, shock or heart failure. Approximate Interval Between Onset and Death RESPIRATORY ARREST SECONDARY TO STROKE immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to for as a ponsequence of physician and the burial-transit Exami that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. The law requires that the death certificate be Physician/Medical as attending p IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death ed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Tyes 2 No 3 Probably Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No certificate has trector, page 2 s To the Hospital or Attending Physician: filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death

To the Funeral Director

completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title RES-000 1,2007 of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE, MD 21224 GEOFFREY 4940 EASTERN AVENUE COLBY 31. Date filed (Month, Day, Year) 32. Rafistrar's Signature State JUL 0 6 200 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** ROBERT ARLEN WHITE, SR. July 2. 2007 11:00 A<sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner STELLA-MARIS HOSPICE Tinoniun Baltimore County If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 M 2 □ F Yrs. 214-26-1098 Director 77 Dec 19, 1929 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Director Baltimore County Maryland Timonium 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or 2300 Dulaney Valley Road 21093 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If ¶es, Give Year or Dates: mportant: if item 27 is marked other than "natural", or any injury or other traumatic event, the Medi-al Examir 1 ☐ Yes 2 No Specify: Specify: ģ 3 ₩idowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) State of Maryland Elementary/Secondary (0-12) College (1-4or 5+) Loan Officier Industrial Development 4+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ould be Harry Fuller White Lillian E. Dorfler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2. Department of Health a Important: If Item 27 is Scott H. White (Son) 208 Midhurst Road, Balto. , MD 21212 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Green Mount Crematory 7/5/2007 Baltimore, Maryland 21. Signar ve of Fineral evidence seems of Marctin D. Lawson 23 TETCHELL WIEDEFELD FUNERAL HOME, INC. 6500 York Road, Baltimore, Maryland 21212 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final VASCULAR Accide **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine bunial-transit and Due to (or as a consequence of) attending physician Physician/Medical the as IF FEMALE: use If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No the 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Records. pe 1 Tyes 2 No 3 Probably Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy certificate 1□ Yes or Vital Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2N No 2 1 Inpatient 2 ER/Outpatient 3□ DOA this completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Deal 28b. Time of Certification: After Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide ō To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29b. Signature and tiple of certifier 29d. Date signed (Month, Day, Year)

State

Registrar

DHMH 17 Rev 1/2001

2300

Dylaney Villey

MP

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Doom

32 legistrar's Signature

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31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** Month nne Irene V Wessels /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ISMYN Baltimore WashingtonMedical Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Vear) Months Days 1 □ M 2 🕅 F Director 219-30-7359 80 06/28/1927 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at MD Anne Arundel Glen Burnie Director 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? "natural", or items 23a 115 Ferndale Road 21061 by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Homemaker <u>Household</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unk Hernandez Unk 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) <u>Linda Wessels/Daughter</u> <u> 24 Maple Dale Ave., Glen Burnie, MD 21061</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Injury or Metro Crematory 6/30/07 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 22. Name and Address of Facility 21. Signature of Forteral Service Stallings Funeral Home, P.A. 3111 Mountain Rd., Pasadena, MD 21122 caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. 23a. Pa 1. Enter the lisease, or complications that shick, or heart failure. List only one cause or Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O.1 signed by the a 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an has autopsy certificate 1∐ Yes 2 No or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 3□ DOA Certification: To 1 🗌 Yes 1 npatient 2 ER/Outpatient Division or within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 8 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide \*Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. To the 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

State

31. Date filed (Month, Day,

Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

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32. Registrar's Signature

## 07-04804

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amela Willey	State of Maryland / Department 1-For State Certificate Registrar	of Dooth	Reg. No. 2011 2 11
Physician/ /ledical Examiner	1. Decedent's Name (First, Middle,Last)	2. Date of Dea Month June 24,	Day Year 1028 brs
V -	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death Havre de Grace	4c. County of Death Harford
Funeral	Harford Memorial Hospital  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		irth(MM/DD/YYYY) 9. Birthplace (State or
Director	222-52-2359 1_M 2XF 47	Yrs. Months Days Hours Min. 11/18	3/1959 Foreign Country) MD
any	Usual Residence of Decedent  10a. State  10b. County  10c. City, Town or Lo	cation	10d. Inside City Limits
	PA PA	West Grove	1 Yes 2 X No
th the Maryland 23a or 28a-f sho notified at once.	172 South Jennersville Road	10f. Zip Code 19390	10g. Citizen of What Country?  USA
with the ms 23a be notificated	11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	
0036 within 72 hours after death with the Maryland giene her than "natural", or items 23a or 28a-f she Medical Examiner must be notified at once ompleted by Funeral Director	1 Yes 2 X No	Yes 2 X No specify:	specify: White
ours aft	or Dates:	dent's Usual Occupation (Give kind of work done g most of working life. DO NOT use retired)	16b. Kind of Business/Industry
5-0036 ed within 72 hours tygiene other than "natur the Medical Exam	Elementary/Secondary (0-12) College (1-4 or 5+)	Homemaker	Household
다 를 뜻 를 되 O		18.Mother's Name (First, Middle	, Maiden Surname)
21215-0036 uld be filed within 7 Mental Hygiene marked other than c event, the Medica fo Be Comple		No vella	Farris umber, City or Town, State, Zip Code)
e, MD and 2 sho Health and item 27 is		2 South Jennersville Roa	d, West Grove, PA 19390
P S S = H	1 Burial 2 X Cremation 3 Removal from State crematory of	rotherplace) July 02 rematory Inc. 2007	
altin mit. P. partme portan ury or		22. Name and Address of Facility Stallin 3111 Mountain Road, Pa	
m ឱ្ង≝≣ Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not ent		irrest, shock, or heart Approximate Interval
/Medical	failure. List only one cause on each line.  Immediate Cause (Final disease a. Atherosclerotic cardioval)		Between Onset and Death
annici	or condition resulting in death)  Due to (or as a consequence of):		
aminer	Sequentially list conditions, if any, leading to immediate cause. Enter underlying cause		
ted Insit	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):		
e be executed sysician and burial - transit ledical Ex	X UNPENDED AMENDED #23a,27, perME,g870, 8	/9/07 TT	
8760 ificate b ig physi	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2	Fetal death 3 Ectopic pregnancy	23d. Date of delivery  Month Day Year
Division of Vital Records, P.O. Box 68761 for the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the bedical Certification: To Be Completed by Physician/Me	past 12 months?  1 Yes 2 No 9 V Unknown  9 Unknown	Other (Specify)	
O. Bo at the des d by the strached for	Part II. Other significant conditions contributing to death but not resulting in	and directlying edges given in t art ii	tobacco use contribute to the cause of death?
Division of Vital Records, P.O. tal or stending Physician: The law requires that the rs after death.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detached in by the funeral director, page 2 should be detached artification: To Be Completed by Pl		1	res 2 No 3 Probably 4 Unknown as an 24b. Were autopsy findings available
Records, The law requires fricate has been significate by page 2 should be Completed		aut	topsy prior to completion of cause of death?
Vital Recystian: The list certificate ligitector, page		1 ✓ Yes 26 Place of Death (Check only one)	s 2 No 1 Yes 2 No
f Vita Physici er this co	examiner? 1 V Yes 2 No Hospital: 1 Inpatient 2 V ER/Outpa 27. Manner of Death 28a. Date of Injury 28b. Time		Residence 6 Other:
vision of vor Attending Photograph or Attending Photograph. Director: Affect in by the funeral information: Tification: T	1 X Natural 5 Pending (Month, Day, Year)	1 Yes 2 No	
Division o spital or Attending tours after death. neral Director: Aft filled in by the fune Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)	street, factory, office building, etc. 28f. Location or Town	n (Street and Number or Rural Route Number, City n, State)
Divis  To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b edical Certific		occurred at the time, date and place, and due to the ca	ause(s) and manner as stated.
To the IIc within 24 To the Fu complete!	one) 2 Medical Examiner: On the basis of examination and/or investant and manner stated.	stigation, in my opinion, death occurred at the time, da  29c. License number	ate and place, and due to the cause(s)  29d. Date signed (Month, Day, Year)
	29b. Signature and title of certifier	O.C.M.E.	June 25, 2007
	30. Name and address of person who completed cause of death (Item 23a)	Para Street Bellinera MD 04004	
State		Penn Street, Baltimore, MD 21201	
Registra	1111 6 5 2007   Military Ser A		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Nancy Lee Whistler July 2, 2007 2:20 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2 👿 F Director 65 Jan 6, 381-42-1768 Ohio Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Anne Arundel Annapolis 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 84 Old Bottom Road 21401 USA filed within 72 hours after death Hygiene. Funeral 14. Race - American Indian, unk 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: Maryland 21215-0036 white 1 ☐ Yes 2 No þ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) nd 2 should be filed within 7 slih and Mental Hygiene.
27 Is marked other than "r fraumatic event, the Med Elementary/Secondary (0-12) College (1-4or 5+) 12 teacher education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elmer Douglas Whistler Mary Isabell Triplett ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Is m any Injury or other traum Carol Kerr/sister 1114 Little Magothy View Annapolis, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) 21. Signature of cuneral Service 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 ivector 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** Pulmoioner HYPERTENSIL disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed burial-tran Due to (or as a consequence of) attending physician for use as the buria Physician/Medical as 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) the detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş pe 6 No. TELOMA 1 ☐ Yes 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has autopsy performed? Yes 2 No certificate 1□ Yes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 10 Hospital: 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA P this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

Division or Vital Records, P.O. Box 68760,

: After Hospital or Attending death. after death | Director: d within 24 hours a Medical

29a. Certifier (Check only one)

3 Suicide

4 Homicide

and manner stated.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

6 ☐ Could not be

determined

29c. License number D39037 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DSMITCHEL

Anne Arundel Medical Center

Annapolis,MD 21401

State Registrar 31. Date filed (Month, Day, Year) 0 6 2007



To the

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1. Decedent's Name (First, Middle, Last)

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-	O Time	of Death	
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4:10 PM

Physician	
/Medical	
Examiner	

Funeral Director

rmit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan partment of Health and Mental Hygiene.
portant: If item 27 Is marked other than "natural", or items 23a or 28a-f show y injury or other traumatic event, the Madical Examiner must be notified at

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

nıne	er er	HARBOR H					BALTIN	IORE	eau	70.	odiny of Dea		
al or		5. Social Security Number 240 – 26 – 758			8 4	t birthday)_ Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M	lin. (Month, Da	av. Year)	Co	ountry)	ate or Foreign
-	or		County	RUNDEL	2 .				17 237			10d. Insid	e City Limits
	ect	10e. Street and Number					10f. Zip Code			10g. Citiz	en of What Co	ountry?	
	aj Di		KS TEE	RRACE				21060	)	3	USA	,	
	by Funeral Director	11. Marital Status  1 ☐ Never Married 2  3 ☒Widowed 4 ☐ D	_	Armed Forces?	o US			lispanic Origin? an, Mexican, Pu Specify:	? (Specify Yes or No uerto Rican, etc.)		14. Race - American Indian, Black, White, etc.  Specify: BLACK		
	eted				1	16a. Decede	ent's Usual Occup aind of work done	nation during most of	working	16b. Kin	d of Business	Industry	
	Completed	Elementary/Secondary	(0-12)	College (1-4or 5-	+)					UNI	TED A	IRLI	IES
	To Be C	17. Father's Name (First, JOHN YATE								, Maiden S	Surname)		
				ES/DAUGH									
			mation 3 🗆		LOUI	e of Dispos netery, crem DON I	ition (Name of atory or other pla PARK CE	<sup>ce)</sup> 7/			,		
ouce.		21. Signature of Funeral	Service Licen	see A.	Sur								
n al		23a. Part I Enter the dis shock, or heart failu Immediate Cause (Final disease or condition resulting in death)	ase, or comp ire. List only o			Do not ente	r the mode of dyi	ng, such as care	diac or respiratory a			Approxi Interval Onset a	mate Between and Death
er	dical Examiner	Sequentially list condition if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	is, ate	b. Hyper- Due to (or as a	tensi a consequen	OV nce of):							
	Physician/Medical	IF FEMALE: 23b. Was decedent pregr in the past 12 month 1 □ Yes 2 □ No 9 □ Unknown	iaiii	1 ☐ Live birth	2 🗆 Fetal de	eath 3□				23	3d. Date of del Month	livery Day	Year
	ya F	_		_		ng in the un	derlying cause giv	en in Part I.	23e. Did 1	obacco us	se contribute to	the cause	of death?
					٤			****	_ 1 🗆	Yes 2□	]No 3∏Pi	robably 4	Unknown
	Completed				onav	MAINTENNANCE   18. Mother's Name (First, Middle, Maiden Surname)   EMMA DIXON							
1	Re	25. Was case referred to examiner?	-	Hospital:		•	Oth						
	0	1 ☐ Yes 2 No 27. Manner of Death		Inpatier			опрои	4 LI Nursiii				cify)	
:	Certification:	2 Accident	investigation	(Month, Day	Year)	Injury	M 1 🗆						
	Certif	4 ☐ Homicide	ACT   ACT		vumber,								
	Medical	29a. Certifier 1 (Check only one) 2 N	Certifying Phylledical Exam	iner: On the basis of	examination	edge, death n and/or inv	occurred at the ti estigation, in my	me, date and pl opinion, death o	ace, and due to the occurred at the time,	cause(s) a date and	and manner as place, and due	s stated. e to the cau	se(s)
:	Me	29b. Signature and title of		House Str	CC 17hV	leiriar						_	ır)

DHMH 17 Rev 1/2001

State Registrar Veena Rao Harbor Hospital 3001 S. Hanover St. Baltimore, Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

			1 - State Registrar			Certificate of	Death		Reg. N	.2007	217	82
ľ	Physic /Medi		Decedent's Name (First, Middle		nna Zai	menski		2. Date of Month		ay Year 2007	3. Time of De	eath M
A CONTRACTOR OF THE PARTY OF TH	Examil Funeral Director		4a. Facility Name (If not institution  FRANKLIN  5. Social Security Number  216-20-0739  Usual Residence of Decedent	EUARE HO. 6. Sex 7. Age 1□ M 2☑F	Spilal e (In yrs. last birt		se dA	24 Hrs. 8. Date of (Month	40	BAITI) 9. Birth	MORE place (State or F	oreign
	e Maryland 3a-f show tified at	Director	10a. State 10b. County	ltimore	10c. City, Town	or Location	Dunda	1k			10d. Inside City I	
	with th la or 20 t be no		10e. Street and Number 400 Trappe	Pond.		10f. Zip Code		21222		itizen of What Cou	-	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status  1 Never Married 2 Marri  3 Nover Married 4 Divorced	12. Was Decedent 8 Armed Forces?		13. Was Decedent of If Yes, specify Cu 1 ☐ Yes 2€ No.	Hispanic Or ban, Mexica			nited Sta  14. Race - Americ Black, White,  Specify:	can indian, etc.	
2-00	72 hou natura lical E	eted	15. Decedent	t's Education	16a.	l Decedent's Usual Occ <i>(Give kind of work don</i>	upation	et of working	16b. I	Kind of Business/In	White	
21215-0036	ed within 'giene.'er than "	Completed	Elementary/Secondary (0-12) 12 Years	College (1-4or 5	+)	life. DO NOT use retir Homemak	ed)			Own Ho	me	
Maryland	d be fill antal H ed oth	Be	17. Father's Name (First, Middle, George Crawf.	-			18. Mothe	er's Name (First, Mi		n Surname)		
ary	should and Me s mark umatic	ဥ	19a. Informant's Name/Relationsl	<u>-</u>	19b.	Mailing Address (Stree	et and Numb	Anna Ric		or Town, State, Zip	Code)	
	and 2 ealth a n 27 is		Elizabeth Szyd	lowski (Daug		6426 Oak P						0
Baltimore,	Pages 1 nent of H ant: If iter ury or oth		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (S)		cemeter	Disposition (Name of t, crematory or other pi Hill Cemet		Date 7/7/2007		ocation - City or To Len Burni		
Balt	Departi Departi Mporta Iny Inji		21. Signature of Funeral Service	Licensee		22. Name and Add Duda-Ruc	ress of Facili	ty eral Home			-	
68760,	Certificate be executed disciplinate by the prival-transit process as the burial-transit process.	//Medical Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Du to (or as a c.	the death. Do nie.  a consequence of a c	f):	ing, such as	cardiac or respirato	ry arrest,		Approximate Interval Betwee Conset and Dea	en ith
.O. Box	the death cer y the attendir sched for use	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death	3 □Ectopic pregnan 5 □ Other (specify)	су		-	23d. Date of delive Month	ery Day Yea	ır
ords, P	The law requires that the death ate has been signed by the atter bage 2 should be detached for u	b	Part II. Other significant condition	ins contributing to death bu	it not resulting in	the underlying cause g	iven in Part I			use contribute to tl		
Vital Records, P.O.	Physiclan: The law I r this certificate has be ral director, page 2 sh	Completed	25. Was case referred to medical					10 4		prior to co death?	psy findings ava mpletion of caus 2 No	ilable e of
	nysicla nis cert directe	To Be	examiner?	Hospital: 1 Inpatie	nt 2 ER/Out	patient 3 DOA	Ub	of Death Check of ursing Home 5 1	-	6 □Other (Specif		
Division or	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director, p		27. Manner of Death Natural 5 Pending 2 Accident investig 3 Suicide 6 Could n	ation		ury We		28d. Descr		ury occurred	·	
Ď Ž	oital or Att urs after de ral Direct	Certification:	4 ☐ Homicide determi	ned building, etc	: (Specify)	n, street, factory, office		City or	Town, Stat			1
	To the Hosp within 24 hou To the Fune completely fi	Medical	29a. Certifier 1 ☐ Certifyin (Check only 2 ☐ Medical I	g Physician: To the best of Examiner: On the basis of and manner sta	examination and	death occurred at the /or investigation, in my	time, date ar opinion, dea	nd place, and due to ath occurred at the ti	the cause(s me, date an	s) and manner as s nd place, and due to	tated. the cause(s)	
)	To To t	Σ	29b. Signature and title of certifier	H. volu	_		se number	56		ate signed (Month,		7
DH	Sta Registr MH 17 Rev 1/2	ar	30. Name and address of person of the control of th		eath (Item 23a) (1 91 56 ur's Signature	ype, Print) HILADE	SHA	Ros Scut	c 20	OU BALTO	1 MD 21	237
						ODIGINIAL						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

Registrar

**JUN 28** 

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			For State		State o	f Marylan	•	artment of F <i>rtificate of I</i>					01701
N			Registrar  1. Decedent's Name	(First, Middle	, Last)			imodic or i	Dealit	2. Date of De		Van	3. Time of Death
1	Physici /Medic	_	Σ	enver)	B. Allen					JUNE I		∞ <sup>Year</sup>	659 AM
	Examin	er	4a. Facility Name (If		-		ا ا	4b. City, Town, o	_	ith		ty of Death	
10.19.	Funeral		BALTIHOLE 5. Social Security Nu		6. Sex	7. Age (In yrs.		If Under 1 Year	SURNIE If Under 24 Hrs	s. 8. Date of Birt			place (State or Foreign
ı.	Director		238.44.27		1 X M 2□ F	75	Yrs.	Months Days	Hours Min	8. Date of Bird (Month, Da October	6,193	1 Nort	th Carolina
	land ow It		Usual Residence of I 10a. State	Decedent 10b. County		10c. Cit	y, Town or Lo	cation				1	10d. Inside City Limits
	Mary a-f sho	tor	W.V.	Hampsh	ire		Romne	y					1 □Yes 🎢 No
	or 28	Direc	10e. Street and Num					10f. Zip Code			10g. Citizen of	f What Cour	ntry?
	s 23a	rall		poorwi	111 Drive	adant Francis III	0 40 1	2675		0:t- V N-		S.A. ace - Americ	oon Indian
21215-0036	iges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Marrie 3 ☐ Widowed		ied 1 ☐ Yes If Yes, Gi Year or D	ve		Was Decedent of H f Yes, specify Cuba 1 □ Yes 2 1 No	an, Mexican, Pue	specify fes of No erto Rican, etc.)	Spec	ack, White,	
2-0	- : 30	etec	(Specia	15. Decedent fy only highes	s's Education of grade completed)		16a. Deced	lent's Usual Occup kind of work done OO NOT use retired	ation during most of w	orking	16b. Kind of		•
121	within ene. than "	Completed by	Elementary/Secon	dary (0-12)	College (	1-4or 5+)		spector	<i>z)</i>		Baltimo Authori		ousing
d 2	il Hygi other rent, t	Be C	17. Father's Name (F	First, Middle,	Last)			Брессот	18. Mother's Na	ame (First, Middle,			
/lar	uld be Menta arked arlc ev	To B	John	1 E. Al	len						ie Smi		
, Maryland	and 2 sho raith and 1 27 is ma er trauma		19a. Informant's Nar Betty A1				1	ng Address (Street Thippoorw					,
Baltimore,	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hyglene. Importants: If item 27 is marked other than any Injury or other traumatic event, the Me Once.		20a. Method of Dispo 1X Burial 2 ☐ 4 ☐ Donation	Cremation	3 □Removal from pecify)	State	emetery, crer. idon Pa		ery Jur	- 1		imore,	Maryland
Balt	permit. Departi Importi any Inj		21. Signatur of Fur	peral Suvice	Licensee Jours	2-		Name and Addre		_		-	
	Physician /Medical Examiner	-	23a. Part1. Enter the shock, or heart Immediate Cause (f disease or condition resulting in death)  Sequentially list con if any, leading to imm	ditions,	a. No Due to b.	used the deat ach line.  COO  ( r la a conseq  (or as a conseq	uence of):	er the mode of dyir  I NE	Arch	ac or respiratory a	e		Approximate Interval Between Onset and Death
68760,	ficate be executed physician and is the burial-transit	edical Examiner	that initiated events resulting in death) La	lying njury	c	(or as a conseq	uence of):						
P.O. Box	that the death certific hed by the attending p detached for use as i	Physician/M	IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	1□Live	tcome pf pregna birth 2 □ Feta nant at time of c own	al death 3 □	Ectopic pregnancy Other (specify)	y			Date of delive Month	ery Day Year
	o b g	by Pł	Part II. Other signific						en in Part I.				he cause of death?
ord	w requir been si should	ted	Dense	iwi	or KI	M//W	3 V W			. 18	Yes 2□No	3 ∐ Prot	bably 4 ∐Unknown
al Records,	: The law cate has by page 2 sh	Completed by								24a. Was autoj perfo		prior to co death? 1 Yes	opsy findings available impletion of cause of
or Vital	Physician: this certific	Be	25. Was case referre		Hospital:		IED/O. (****)	o Oth	er.	eath (Check only o			
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ion	Attending r death. ector; After by the fune	atio	1 Natural 2 Accident	5 ☐ Pendin investig	gation	th, Day Year)	Injury		Yes 2∐No				
Division	al or Attend s after death al Director; / ed in by the f	Certification:	3 Suicide 4 Homicide	6 Could i determ	inad   Zoe. Flace	of injury - At he ing, etc. (Special	ome, farm, str	eet, factory, office		28f. Location ( City or To	Street and Nur wn, State)	nber or Run	al Route Number,
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Medical (	(Check only one)	2 Medical				vestigation, in my	opinion, death oc				
	Withi To t	Σ	29b. Signature and t	title of certifie	r	10 . 5		29c. Licens	e number		29d. Date sign		Day, Year)
	6		Y			MD		03	2010		6/5	Folce	21/1
			30. Name and address	Nuner	am as	se of death (Iter	45 C	Print) A Yww	d R	ond G	olen P.	invo	21061 e MD
	Sta Registi		51. Date filed (MOTE	UN 2 1	2007	Selver J		arti					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 10 HT 11 M 20 0 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Dec. 12, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1**M**M 2□F 89 Ohio Director 211-09-1523 Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show ms 23a or 28a-f sho r must be notified a Maryland Prince George Lanham 1 ☐ Yes 2 X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. 20706 USA 5505 75th Ave Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No 1941—
If Yes, Give 1045 14. Race - American Indian. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 "natural", or White 1 ☐ Yes 2 No Specify. 1945 3 ☐ Widowed 4 ☐ Divorced Year or Dates: er than "nature, the Medical E 16a. Decedent's Usual Occupation 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Machinist/Model Maker Dept. of Navy 7 Is marked other traumatic event, t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Andrew Joseph Amber Grace Frances Coonev 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ellen G. Amber/Wife 5505 75th Ave. Lanham, Md. 20706 Item 27 I 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of I Important: If Its any Injury or o once. 1 Burial 2 □ Cremation 3 □ Removal from State Maryland Veterans Cem 6/25/07 Cheltenham, MD. 4 Donation 5 Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home PA 21. Signature Funeral Service Licenses 6160 Oxon Hill Road Oxon Hill, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to ( if as a consequence of): Examiner A Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed bunial-trar Due to (or as a consequence of). Division or Vital Records, P.O. Box 68760, physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the s should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an page 2 s performe 1□ Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Medical Certification: To Be 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 ☐ Pending investigation ours after death.

neral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely and manner stated 29c. License number 30. Name and address of person he completed cause of death (Item 23a) (Type, Print) ENTA MO 1 LITAN La 445 DEFENSE 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** Blake 18 2:00 PM auline Geneva 9 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b City Town or Location of Death **Examiner** hestertown River Manor Kent If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Pay) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 6. Sex Birthplace (State or Foreign Country) -22-592 Days 1 M 2 K 81 Yrs. Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits or 28a-f show item 27 is marked other than "natural", or items 23e or 28a-f shov other traumatic event, the Madical Examinations to the result for Kent hestertown 1 ☐ Yes 2 ☐ No Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA andford 24801 21620 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 25 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No À Specify. Black Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 7/ h and Mental Hygiene. 7 is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) ineworker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Be Alberta Dencer Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) iges 1 and 2 s it of Health an 24801 Landford 89 Blake husband Chestertown, MD 21620 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 important: If it 1 Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 6/23/07 21. Signature of Funeral Service Licensee TO WN Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) certificate be executed burial-transit Due to (or as a consequence of): the attending physician Box 68760 Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐ Pregnant at time of death 5 Other (specify) P.O. 9☐ Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, pe 1 Yes 2 No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed? 2 10 No 2□ No 1 TYes To the Hospitel or Attending Physician: funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ၉ 1 Tyes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: 1 Natural 5 Pending death. М 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KINK, WUN, 465 Washington tre 31. Date filed (Month, Day, Year) Registrar

07-04579 Thelma Biddle

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		1- For State Registrar			Ce	rtificate of	Death				R	Reg. No.			
Physici	an/	Decedent's Name (First)	, Middle,Last)							12	2. Date of Dea	ath		3. Tir	me of Death
dical Exami	iner	Thelma	M. Bi	ddle						ŀ	Month June 15,	2007	Year	14	425 hrs
		4a. Facility Name (if not in			mber)	4	b. City, To	wn, or Lo	cation of D	Death		40	. County of De	ath	
		400 block Cayots	Corner R	oad			Chesap	oeake (	City				Cecil		
Funeral		5. Social Security Number	6. Sex		7. Age (In yrs. I	last birthday)	If Under	1 Year	If Under 2	4Hrs.	8. Date of Bi	rth(MM/	(DD/YYYY) 9.	Birthplac	e (State or
Director		221-40-95	75 1	M 2XX	7.0	Yrs.	Months	Days	Hours	Min.	04/0	- / 4	For	eign <b>M</b> j Country)	iddletow
		Usual Residence of Dece		<sup>™</sup> 2X.X	70	TIS.	L				04/2	5/1	937		DE
any		10a. State 10b. C			10c. City	, Town or Location	n .							10d.	Inside City Limits
*			ew Ca:	~ <del> </del> ] _	1.00.0.0										Yes 2 XNo
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Mary 28a dat	Director	10e. Street and Number					10f. Zip C	ode			I I A	10g. Citi	zen of What C	ountry?	
ith the Maryland 23a or 28a-f show notified at once.		842 Chur	chtown	n Road	E		1 :	9709	)			U	J.S.A.		
with ms 2; be n	Funeral	11. Marital Status			edent Ever in U						cify Yes or No	0-	14. Race - An		dian, Black,
r death w or items must be	Š	1 Never Married 2.	XXMarried	Armed Fo	2 X No	IT YE	es, specify	Cuban, K	nexican, P	uerto F	tican, etc.)		White, etc		
ifter		3 Widowed 4	Divorced	f Yes, Give Yea		1	Yes 2	X No :	specify:				Specify:	Whit	e
71215-0036 Id be filed within 72 hours after dental Hygiene. narked other than "natural", event, the Medical Examiner	d by	15. Decedent's Education			de completed)	16a. Decedent						16b. l	Kind of Busine	ss/Industr	у
72 hc	Completed	Elementary/Secondary	(0-12)	College (1	-4 or 5+)	during mo	st of worki	ng life. D	O NOT us	e retire	ed)				
thin thin than the	ᅙ	12th				Home	emake	er				Do	mesti	c/Ow	n Home
5-0036 led within 7 Hygiene. I other than	ਨੂ	17. Father's Name (First, I	Middle, Last)			·		18	.Mother's	Name (	First, Middle,	Maiden	Surname)		
215 e file tal H ked o	Be (	William 1	Elmer	Emers	con				T 2111	~~	Dalla	C ~			
2121 vald be fill Mental P marked c event, t	0	19a. Informant's Name/Re	lationship (Ty	pe, Print )	5011	19b. Mailing	Address	(Street a	and Numbe	er or Ru	ıral Route Nu	mber, C	aham Sity or Town, St	ate, Zip (	Code)
imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Institute 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once		Lester T	C B	4166	/ Uu ah a	2842	hure	ah+c	strm T	2	Min	. ال <i>ه</i>	<b>L</b>	ъп	10700
and and lealtl		Lester I  20a. Method of Disposition	n	<u>raarc</u> ,	20b.	Place of Disposi	tion (Name	of ceme	tery,	<del>.</del>	Date Date	20c.	Location - City	or Town	, State
Ore ges l t of l : If i		1 X Burial 2 Cre			om State	crematory or oth	er place)		- 1						
Limen Part		4 Donation 5 Ot			1 T	ownsend				5/2	0/200	7 T	ownse	ad,	ĎΞ
Baltimore, MD 2121 permit. Pages 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked injury or other traumatic event,		21. Signature of Functal S	iervice Licens	ee \			ame and A			тиг	SON E	יבואוו	RAL H	- TMC	TTO
		Karu-	IN	$\sim \sim$	1	. Do not effe th									DILL C
Physician /Medical		23a. Part I. Enter the disea failure. List only one			aused the	. Do not emer to	monu-or	ahua: o-	on se can	136 OF	nespirator) sa	COCT TO	OCHEMINAL		tween Onset and
Examiner	Immediate Cause (Final disease a Multiple Injuries													Death	
		or condition resulting in de	eath) D	ue to (or as a	consequence of	of):									
	L	Sequentially list condition				- 1)				_				-	
	ine	if any, leading to immedia cause. Enter Underlying	Cause	ue to (or as a	consequence of	OT):									
	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):										-			
outed nd ransi		,	d			_									
of Vital Records, P.O. Box 68760, g Physician: The law requires that the death certificate be executed after this certificate has been signed by the attending physician and neral director, page 2 should be detached for use as the burial - transit	/Medical	UNPENDED		AMENDED											-
760, ficate be g physics the bur	ĕ	IF FEMALE:		23c. If yes,	outcome of preg	gnancy						23	d. Date of deliv	/ery	
187 rtifica ing p	<u> </u>	23b. Was decedent pregna past 12 months?	ant in the	1 Live b			al death	3	Ectopic p	regnan	су		Month	Day	Year
Box 68 e death certif	<u>i</u>	3		4 Pregr	ant at time of d	eath 5 Oth	ner (Specif	5y)				2			3
O. Box 687 at the death certific d by the attending parchet for use as the	Physician	1 Yes 2 1 No 9	Unknown	9 Unkno	own										
tal Records, P.O. cian: The law requires that the certificate has been signed by ector, page 2 should be detach		Part II. Other significant	conditions	contributing to	death but not i	resulting in the u	nderlying c	ause giv	en in Part	1.	1	_	use contribute		
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CO law law e 2 s	립				·	<del></del>						ormed?	death	1?	
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of Vital Records, ng Physician: The law require the this certificate has been simeral director, page 2 should be	Be	25. Was case referred to r examiner?		ospital:				Ι'n	f Death (C			D-111		· · O ·	
of Vit ling Physic After this	유	1 <b>Y</b> Yes 2 N	10	'	npatient 2	ER/Outpatient		<i>'</i> `	at Work?		Home 5		ence 6 🗸 O	ner: Scer	ne
	岸	27. Manner of Death  1 Natural 5	1	28a. Date	or injury , Day,Year)	28b. Time of Ir FOUND:	1 1 I			Iг	28d. Describe <b>Oriver auto</b>				
Division tal or Attendir rs after death.  al Director: A led in by the fu	#   a‡	2 Accident	Pending Investigation	lum 15		1425 hrs		1Ye	s 2 🗸 N	10					
or A of A of the of the	≝	3 Suicide 6	Could not b	28e Plac	e of Injury - At h	nome, farm, stree	t, factory, o	office buil	lding, etc.	12	28f. Location or Town,		and Number or	Rural Ro	oute Number, City
pital purs a	Certification:	4 Homicide	determined	(Specify)	Local Stre	et				4	00 block Ca	yots C	orner Road,	Chesap	eake City, MD
Hos 24 ho Fun etely		29a. Certifier 1 Certify	ying Physicia	n: To the bes	at of my knowled	ige, death occur	ed at the ti	ime, date	and place	e, and o	iue to the cau	ıse(s) ar	nd manner as s	stated.	
Division  To the Hospital or Attendi within 24 hours after death.  To the Funeral Director: A completely filled in by the fi	Medical	one) 2 Medic	al Examiner:	n the basis and manner s	of examination a	and/or investigati	on, in my o	pinion, d	leath occu	rred at	the time, date	and pla	ace, and due to	the cau	se(s)
F > F 8	ĭ Be	29b. Signature and title of		and marrier s			29c.	License r	number			29d.	Date signed (	Month, D	ay, Year)
			//	1				O.C.M	.E.			Jun	ne 16, 2007		
700	8	30. Name and address of	erson who	omnleted cour	se of death /Ita-	n 23a)									
DOM	F	Mary G. Apple M			se or death (Iter Medical Exa		Penn S	treet F	Baltimor	e. Mr	21201				
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	tate	o i. Date liled (Month, Day	IN 2 0		egistar's Signat	An .	£								

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

2007

DHMH 17 Rev 1/2001

**ORIGINAL** 

cause of death (Item 23a) (Type, Print) PTON MD

32 Registrar's Signature

29c. License number

6121 Montrose Rel

29d. Date signed (Month, Day, Year)

Rockville MDZ0852

		1 - For State Registrar	State of Ma		-	rtment of tificate of				iene.		21789
Physic	ian	1. Decedent's Name (First, Middle, La							2. Date of Dea Month	Day Y	ear	3. Time of Death
/Medi			shop						June 20	1	-	3:07 p M
Exami	ner	4a. Facility Name (If not institution, giv				4b. City, Town,		of Death		4c. County of		
		Caroline Nursin  5. Social Security Number 6. S	2	(In yrs. last birt	thday)	Dento		24 Hrs.	8. Date of Birth	Carolin		e (State or Foreign
Funeral Director			□M 21X F		Yrs.	Months Days	Hours	Min.	(Month, Day	, Year)	Country)	ington, DO
iled within 72 hours after death with the Maryland filed within 72 hours after death with the Maryland Hygiene.  Ither than "natural", or flems 23a or 28a-f show out, the Medical Examiner must be notified at		10a. State 10b. County		10c. City, Town	n or Loc	cation					10d.	Inside City Limits
Ba-f.	ctol	Maryland Talbot		Easto	n							1 ☐ Yes 2 ⅓No
or 26	Director	10e. Street and Number				10f. Zip Code			1	0g. Citizen of Wh	at Country	?
ath v	ral	33003 Lovedays	T		140.14		601	:-:-0./0-	a a fu Va a a a Na	U.S	SA American	Indian
er de	Funeral	11. Marital Status 1 Never Married 2 Married	12. Was Decedent E Armed Forces? 1 Yes 2KN		IS. VI	Yes, specify Cu	ban, Mexica	n, Puerto	ecify Yes or No- Rican, etc.)		White, etc.	
Irs aff	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1	☐ Yes 2X No	Specify	:		Specifyil	nite	
within 72 hours after death with the Marylan liene. rithan "natural", or Hems 23a or 28a-f show the Medical Examiner must be notified at	ted	15. Decedent's E		16a.	Deced	ent's Usual Occu	pation	et of work	ing	16b. Kind of Busi		try
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_ ~ ~ ~ ~		Robert L. Bishop								MD 2087		/
s 1 and 2 f Health item 27 other tra		20a. Method of Disposition		20b. Place of	Dispos	sition (Name of latory or other pl	-1		Date	20c. Location - C		, State
mit. Pages 1 ar partment of Hez portent: If item y injury or other ce.	1	XXBurial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Special				k Cemete		June 200	24	lashingto	n Di	
permit. Pages 'Department of t Importent: If ite any injury or ot once.		21. Signal re Funeral Service Lice			22 F	Name and Add	ess of Facil		-	Home Ir		
Departing the permit of the pe	(d. 10)	1 ( undrew	Hole									MD 20901
Physician /Medical Examiner		23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Cerch	10.	SC	The mode of dy	A	-		est,	Int	pproximate terval Between nset and Death
ate be executed hysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of								
	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death		Ectopic pregnan Other (specify)	су			23d. Date Monti		y Year
estha gned be de	Ď	Part II. Other significant conditions of	contributing to death b	ut not resulting in	the un	derlying cause g	iven in Part	l.	23e. Did to	bacco use contrib es 2 No 3		eause of death? y 4 ∐Unknown
aw requir	Completed	hupprter	SION	5					24a. Was a	an 24b. We	ere autopsy	findings available etion of cause of
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sician: The law scertificate has breeder, page 2 s	Be	25. Was case referred to medical examiner?		-/-			26. Plac	e of Deat	th (Check only or	10)		
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ding Phy h. After thi funeral (	tlon:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigatio	28a. Date of Inju (Month, Day	y Year) 28b. 1	Time of njury	28c. In W	uryat ork? ⊒Yes 2.⊑	]No	28d. Describe h	ow injury occurred	1	
el or Attending Phy s after death. I Director: After this din by the funeral d	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	OB Diago of Init	ury - At home, fa c. <i>(Specify)</i>	ırm, stre	eet, factory, office	9		28f. Location (S City or Tow	treet and Number n, State)	or Rural R	oute Number,
To the Hospitel or Whin 24 hours after To the Funeral Dir completely filled in I	edical	29a. Certifier 1 Certifying Pl (Check only 2 Medical Example)	hysician: To the best miner: On the basis of and manner sta	examination an	e, death id/or inv	occurred at the restigation, in my	time, date a opinion, de	nd place, ath occur	red at the time, o	date and place, an	d due to the	e cause(s)
To the within 2 To the complet	Σ	29b. Signature and title of certifier				29c. Lice	nse number	_		29d. Date signed	Month, Day	y, Year)
8		James &	wes	MD		D3	113	16		0-20	-07	7
0		30. Name and address of person who	completed cause of d	eath (Item 23a)	(Туре, І	Print)	a 7	) = ~	1	MC	) ~m	1000
		24 Page Flord (Month 2: March	25 33	0 /74,	CK	37 3	CL	ev	LOU	1100	- d/	6.41_
St Regist	ate	31. Date filed (Month Day, Year)	007 32. Hegistra	ar's Signature	A	orde 1						

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Dav **Physician** 11:30am<sup>M</sup> June 19,2007 Harold D. Bengelsdorf /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Montgomery Suburban Hospital Bethesda If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** M 2□ F Director 104-20-7871 80 May 19,1927 New York Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If flem 27 Is marked other than "natural"; or Items 23a or 28a-f show any linjury or other traumatic event, the Medical Examiner must he appear once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 □ No Funeral Director MD Bethesda Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6516 East Halbert Rd 20817 United States Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: White Be Completed by 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Nuclear Policy Consultant Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဥ Isidore Bengelsdorf Sadie Bengelsdorf 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laurie Horvitz/ Daughter 6705 Loring Court, Bethesda, MD20817 20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 Donation 5 Dother (Specify) 6-22-07 Parklawn Cemetery Rockville,MD 22. Name and Address of Facility Joseph Gawler's Sons, INC 21. Signature of Funeral Service License la 1000 5130 Wisconsin Ave, N.W. Washington DC 20016 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Asthma Exacerbation disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a 1 Ves 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown Cholestatic Jaundice 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 1∐ Yes 2√ No To the Hospital or Attending Physician; Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Nnpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day Year) 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation filled in by the f 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after within 24 hours a To the Funeral I 29a. Certifier 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) title/of-certifier 29b. Signature an 170061302 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Atul Rohatsi, M.D. 8600 Old Georgetown Rd Bethesda, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 21 Registrar

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** James Barnard 06 26 07 0550 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a, Facility Name (If not institution, give street and number) Examiner WMHS-Braddock Campus Allegany Cumberland If Under 1 Year | If Under 24 Hrs. | Hours | Min. Birthplace (State or Foreign Country) 6. Sex 1 M 2 □ F 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Director Maryland August 07, 1957 Usual Residence of Decement Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 28a-f show a or 28a-f show t be notified at 1 ☐ Yes 2 No Director Lonaconing Allegany Maryland 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 21539 16109 Douglas Hill Avenue 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 No 1 Never Married 2 Married 1 ☐ Yes 2 No ò 3altimore, Maryland 21215-0036 Yes, Give Specify: ģ 3 Widowed 4 Divorced natural 16b. Kind of Business/IndustryWhite Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) is marked other than permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien Important: If item 27 is marked other the any Injury or other traumatic event, the ans Injury or other traumatic event, the once. Handyman 18. Mother's Name (First, Middle, Maiden Surname) Service 17. Father's Name (First, Middle, Last) Be ပ Erma Marie Higgins William Barnard Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 16109 Douglas Hill Avenue, Lonaconing, Maryland, 21539 William Bernard, Jr. - Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town. State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State June 29, 4 ☐ Donation 5 ☐ Other (Specify) Moscow Mills, Maryland 2007 Mt. View Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A. MUPE 23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 3 East Main Street Lonaconing, MD 2 15 30 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) UROSNAOCRI week **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-trar Due to (or as a consequence of): attending physician Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an performe 2 1 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA Certification: To After this funeral 28a. Date of Injury (Month, Day Year) 28h. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, 24 hours after death e Funeral Director: within 2

6 ☐ Could not be 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide i 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29b. Signature and title

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

m. D. yamar

State Registrar

Medical

32. Registrar's Signature 31. Date filed (Month, Day, Year) JUN 2 9 200

07-04838 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. John Markle Beachy State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Physician/ Decedent's Name (First, Middle,Last) 2. Date of Death Month Day June 25, 2007 Medical Examiner 1424 hrs <u>John Markle Beachy</u> 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death 7880 National Pike Grantsville Garrett 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 24Hrs. **Funeral** Director Months Davs Hours 213-28-0266 2 F 90 April 30, 191 1 **X** M Maryland Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location Yes 2 X No 28a-f show Grantsville MD Garrett with the Maryland 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? or items 23a or 7880 National Pike 21536 USA 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, Armed Forces? White etc. 1 X Never Married 2 Married Yes 2 X No permit. Pages I and 2 should be filed within 72 hours after 1 Department of Health and Mental Hydgene. Important: If item 27 is marked other than "nature?" 3 Widowed Divorced If Yes, Give Year Yes 2 X No specify: Specify: White traumatic event, the Medical Examiner þ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) **Baltimore, MD 21215-0036** 12 Dairy & Beef Farming Dairy & Beef Cattle 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Joel A. Beachy Be Etta Sarah Livengood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7880 National Pike, Grantsville, MD Evelyn B. Hewitt/Sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Grantsville Cemetery July 2, 2007 Grantsville, MD Donation 5 Other Specify 22. Name and Address of Facility Newman Funeral Homes, P.A. 21. Signature of Funeral Service Licenses Box 275, Grantsville, MD 23a. Part I. Intenthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval only one cause on each line Between Onset and /Medical a. Torso and extremity injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and transit UNPENDED AMENDED Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Month Dav Year

attending physician or use as the burial requires that the death certificate be Records, P.O. certificate Division of Vital this

sician/Medical Live birth 3 Ectopic pregnancy Fetal death past 12 months? Pregnant at time of death Other (Specify) Yes 2 No 9 Unknown Unknown Phy Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Hypertensive Atherosclerotic Cardiovascular Disease Completed 24a, Was an autopsy performed? Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: Other, Inpatient 2 DOA Nursing Home 5 ER/Outpatient 3 Residence 6 V Other: Scene 1 Yes No within 24 hours after death.

To the Fineral Director completely and a second and a second and a second and a second and a second and a second and a second 28a. Date of Injury (Month, Day,Year) FOUND: 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Subject found under tractor FOUND: 1 Natural Pending Yes 2 No Jun 25, 2007 1330 hrs 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) 7880 National Pike, Grantsville, MD determined (Specify) Farm Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier

29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. June 26, 2007

DOME

24b. Were autopsy findings available

death?

1 V Yes

prior to completion of cause of

No

30. Name and address of person who completed cause of death (Item 23a)

2007

Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year,

32. Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 2007 **Physician** June 27, 3:30 Ernest Ray Beachy AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Goodwill Mennonite Home Grantsville Garrett If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Nov • 1, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1**⊠**M 2□F 90 Maryland 216-14-1528 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No MD Garrett Grantsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3441 Chestnut Ridge Rd. 21536 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No þ Specify: Specify: 3 Widowed 4 Divorced White

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Itema 23a or 28a-f ehow empiripary or other traumatic event, the Medical Example and page. Physician

**Funeral** 

Director

death with the Maryland

Baltimore, Maryland 21215-0036

/Medical Examiner

been signed by the attending physician and should be detached for use as the burial-transit

To the Hospital or Attending Physician: The law requires that the death certificete be executed

Division of Vital Records, P.O. Box 68760,

15. Decedent's i				
	Education grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired)	f working	Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)	Stone Mason		sonry
17. Father's Name (First, Middle, Las	st)		Name (First, Middle, Maide	
Simon Beachy			Bender	,
19a. Informant's Name/Relationship	(Type Print)	19b. Mailing Address (Street and Number of		yor Tourn State Zin Code)
		324 Old Salisbury Re		
Leo J. Beachy/Sc 20a. Method of Disposition		Place of Disposition (Name of		
1 ☑ Burial 2 ☐ Cremation 3	☐Removal from State	cemetery, crematory or other place)	20c.	Location - City or Town, State
4 Donation 5 Other (Spec	city) Gr	cantsville Cemetery Jur	ne 30, 2007 d	Frantsville, MD
21. Signature of Funeral Service Lice	ensee	22. Name and Address of Facility	Newman Funera	1 Homes, P.A.
do Sun O	Eumae	P.O. Box 275, G	rantsville, M	ID 21536
23a. Part 1. Enter the disease, or con	mplications that caused the dea	ath. Do not enter the mode of dying, such as ca	rdiac or respiratory arrest,	Approximate Interval Between
Immediate Cause (Final		ve Heart Fail		Onset and Death
disease or condition resulting in death)	a. Due to was a conso	equence of:		
1	To the as a conse	Standard		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conse	aguence of):		
cause. Enter Underlying Cause (Disease or injury	Fre Lan	To The () Ble	red	
Cause (Disease or injury that initiated events resulting in death) Last	c. Due to for as a conse	acuence of:		
	14 00 00 d	/		
	_d. 1100176	Chrosc		
IF FEMALE:	100			
	23c. If yes, outcome of pregr			23d. Date of delivery
23b. Was decedent pregnant	1 ☐ Live birth 2 ☐ Fei	ital death 3 Ectopic pregnancy		
in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fei 4 ☐ Pregnant at time of			Month Day Year
in the past 12 months?	1☐Live birth 2☐Fei			Month Day Year
in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown		23e. Did tobacco	Month Day Year  use contribute to the cause of death?
in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  Part II. Other significant conditions	1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	death 5 Other (specify)	5	b use contribute to the cause of death?
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in the past 12 months?  1  Yes 2 No 9  Unknown  Part II. Other significant conditions	1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	death 5 Other (specify)	1 ☐ Yes  24a. Was an autopsy	o use contribute to the cause of death?  2 No 3 Probably 4 Unknow  24b. Were autopsy findings available prior to completion of cause of
in the past 12 months?  1  Yes 2 No 9  Unknown  Part II. Other significant conditions	1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	death 5 Other (specify)	1 ☐ Yes	o use contribute to the cause of death?  2 No 3 Probably 4 Unknown  24b. Were autopsy findings available prior to completion of cause of death?
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in the past 12 months?  1	1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown  contributing to death but not re	esulting in the underlying cause given in Part I.  26. Place of	24a. Was an autopsy performed?  1   Yes 2   N  Death   Check only one)  ng Home 5   Residence	2 No 3 Probably 4 Unknow  24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No  6 Other (Specify)
in the past 12 months?  1	1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown  contributing to death but not re	esulting in the underlying cause given in Part I.  26. Place of  □ ER/Outpatient 3□ DOA Other: 4 Manual  28b. Time of linjury 28c. Injury at Work?	1   Yes  24a. Was an autopsy performed? 1   Yes 2   N  Death Check only one)  ng Home 5   Residence  28d. Describe how in	2 Use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
in the past 12 months?  1   Yes 2   No  9   Unknown  Part II. Other significant conditions  4   A   A   A    25. Was case referred to medical examiner?  1   Yes 2   A    27. Manner of Death  1   A   A    2   A   A    2   A   A    2   A   A    3   Pending investigated	Hospital: 1 Inpatient 2 Hospital: 2Ba. Date of Injury (Month, Day Year)	esulting in the underlying cause given in Part I.  26. Place of Cther: 4 Nursii  28b. Time of 28c. Injury at	1   Yes  24a. Was an autopsy performed? 1   Yes 2   N  Death Check only one)  ng Home 5   Residence  28d. Describe how in	2 Use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
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in the past 12 months?  1	Hospital: 1 Inpatient 2 Ba. Date of Injury (Month, Day Year) on be deep the passes of examiner: On the basis of examiner: On the basis of examiner:	26. Place of Ser. Injury at Work?  1 Ser. Injury M 1 Ser.	24a. Was an autopsy performed?  1 Yes 2 N  Death Check only one)  1 Residence  28d. Describe how inj  28f. Location (Street a City or Town, Sta	2 No 3 Probably 4 Unknow  24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No  6 Other (Specify)  ury occurred  and Number or Rural Route Number, te)

DHMH 17 Rev 1/2001

State

Registrar

within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral director.

21536

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

31. Date filed (Month, Day, Year)

Robin Bissell, M.D., 124 Miller St., Grantsville, MD

32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

BRIDDELL, ELSIE

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			1 - State Registrar				Ce	rtificate of	Death		F	Reg. No.	200	7 2170
	Physicia	an	Decedent's Name (								Date of Dea Month	Day		3. Time of Death
	/Medic				monds Bride	dell					JNE	18		3:00P M
	Examin	er	4a. Facility Name (If no			. + i	Córea	4b. City, Town, o	or Location of D	eath			County of Deal	
÷	Funeral		5. Social Security Nun		Rehabilita	e (In yrs. lasi		if Under 1 Year			Date of Birt	th	9. Birt	thplace (State or Foreign
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	the N 28a-f notifie	rect	MD  10e. Street and Numb	Worces	ter	Бе	: L L J. II	10f. Zip Code				10g. Citiz	zen of What Co	ountry?
	3a or	<b>Funeral Director</b>	517 Flowe		+			218	311			US	SA	
	death	nera	11. Marital Status	I DETEC	12. Was Decedent I Armed Forces?	Ever in U.S.	13.	Was Decedent of I		? (Specify	Yes or No-	- 1	14. Race - Ame Black, Whit	
٥	after or ite	/ Fu	1 Never Married		1 ☐ Yes 2 ☐ ②	No	- 1	1 ☐ Yes 2 ☑ No		derio i no	ari, 616.)		Specify:	ie, eic.
9500-612	filed within 72 hours after death with the Maryland Hygiene. kther than "natural", or items 23a or 28a-f show ant, <u>the Medical Examiner must be notified at</u>	d by	3 ☐ Widowed 4		Year or Dates:								B :	lack
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פ	e filec al Hyg othe vent,	Se C	17. Father's Name (Fi	irst, Middle, Las	t)				18. Mother's	Name (Fi	rst, Middle,	Maiden :	Surname)	
Z	ould b Menta arked	To E	Joseph :	Edmonds					Ruth	n Ber	ry			
Maryland	12 should be filed v n and Mental Hygie is marked other t raumatic event, th		19a. Informant's Nam William Br					ng Address (Stree				-		
	1 and Healtl em 27 ther t		20a. Method of Dispos		nuspand	20b. Plac		Flower S		- Ber			cation - City or	
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<b>Банттоге</b> ,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		4 □ Donation 5  21. Signature of Fune			St. 1		2. Name and Address	,				-	•
ñ	permi Depai Impor any fr		Hatr	vu)	a fall	2 V		Jolley Mem	orial Cha	pel,	P.A	1213	Jersey R	Road
1	#		23a. Part1. Enter the shock, or heart	disease, or con failure. List only	nplications that caused one cause on each lip	he death. le.	Do not en	ter the mode of dy	ing, such as car	rdiac or re	spiratory ar	rrest,		Approximate Interval Between
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.C. Box		_	resulting in death) La:  IF FEMALE: 23b. Was decedent p	oregnant nonths?	b. Type Due to (or as  c. Hypert Due to (or as  d. 23c. If yes, outcome	a consequer a consequer pf pregnanc	bete: nce of): re Hea nce of):	art Disea	ise		<u></u>	2		Years
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Records, P.O. Box	iclan: The law requires that the death certificate be executed certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent p in the past 12 m 1 Yes 2 J 9 Unknown Part II. Other signific  Recurrer  25. Was case referre examiner? 1 Yes 2 N	oregnant nonths? No eant conditions ont Cathe	b. Type Due to (or as  c. Hypert Due to (or as  d. Due to (or as  d. Pregnant at 9 Unknown  contributing to death be  eter Sepsis  Hospital: 1   Inpatie	pf pregnanc 2 Fetal de time of deal	betes nce of): re Hearnce of): re Hearnce of): ng in the u	□Ectopic pregnanc □ Other (specify) □ underlying cause gi	ven in Part I.  26. Place of her:	Death (C	1 \( \)\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	obacco u Yes 2[ an posy primed? 2[]No prie)	Month  se contribute te  No 3 P  24b. Were a prior to death? 1 Yes  6 Other (Spe	Years  Day Year  of the cause of death?  Trobably 4 Unknown  utopsy findings available completion of cause of second seco
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or Vital Records, P.O. Box	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit	Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent p in the past 12 m 1	oregnant conditions nt Cather cather conditions investigation determined conditions cather ca	b. Type Due to (or as  c. Hypert Due to (or as  d	pf pregnanc 2 Fetal de t time of deal  ut not resultin  ut not resultin  ut y Year)  of my knowle f examinatio	bete: nce of):  e Heat nce of):  gy eath 3[ th 5[  av/Outpatie  Bb. Time o  Injury  e, farm, st  edge, dea	Disea    Ectopic pregnand   Other (specify)	ven in Part I.  26. Place of her: 42. Nursing years and a popinion, death se number	Death (C ng Home 28d 28f.	24a. Was autor performed to the control of the cont	obacco u Yes 2 an psy prmed? 2 No one) dence 6 how injury Street and wn, State, cause(s) date and	Month  se contribute to No 3 P  24b. Were a prior to death? 1 Yes  6 Other (Spectroscopy occurred)  and manner and place, and du	Years  Day Year  of the cause of death?  Tobably 4 Unknown  utopsy findings available completion of cause of some sof sof some sof some sof some sof some sof some sof some sof some sof some so
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or Vital Records, P.O. Box	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent p in the past 12 m 1	pregnant conditions at Cather cather	b. Type Due to (or as  c. Hypert Due to (or as  d	pf pregnanc 2 Fetal de time of deal ut not resulting y Year)  of my knowled f examination ated.	bete: nce of):  e Heanne of):  gy eath 3[ th 5[  mg in the company of the company	Diseat Diseat    Compared to the content of the course of	ven in Part I.  26. Place of her: 42. Nursing years and a popinion, death se number	Death (C) ng Home 28d 28f.  place, and occurred	24a. Was autor period of the ck only	obacco u Yes 2[ an psy ormel 2 No one) dence 6 how injury cause(s) date and	Month  se contribute to No 3 P  24b. Were a prior to death? 1 Yes  6 Other (Spectroscopy occurred)  and manner and place, and du	Years  Slivery Day Year  of the cause of death?  Trobably 4 Unknown  utopsy findings available completion of cause of secify)  Aural Route Number,  as stated.  te to the cause(s)
or Vital Records, P.O. Box	iclan: The law requires that the death certificate be executed certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transit	Medical Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent p in the past 12 m 1	pregnant conditions ant Cather cather conditions investigation of the conditions of	b. Type Due to (or as  c. Hypert Due to (or as  d	pf pregnanc 2 Fetal de t time of deal ut not resultin  and the series of	bete: nce of):  e Heanne of):  gy eath 3[ th 5[  mg in the company of the company	Diseat Diseat    Compared to the content of the course of	ven in Part I.  26. Place of her: 42. Nursing years and a popinion, death se number	Death (C) ng Home 28d 28f.  place, and occurred	24a. Was autor period of the ck only	obacco u Yes 2[ an psy ormel 2 No one) dence 6 how injury cause(s) date and	Month  se contribute to No 3 P  24b. Were a prior to death? 1 Yes  6 Other (Spe y occurred  d Number or R  and manner a at place, and du	Years  Slivery Day Year  of the cause of death?  Trobably 4 Unknown  utopsy findings available completion of cause of secify)  Aural Route Number,  as stated.  te to the cause(s)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUN 2 2

2007

egistrar's Signature

Registrar
DHMH 17 Rev 1/2001

State

14-6

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

a

31. Date filed (Month

seem

Year) 26 2001

Division or Vital Records, P.O. Box 68760, within 24

> State Registrar

29b. Signature and title of certifier

Manesh G. Nachnani M. D.
Date filed (Month, Day, Year) 32. Applicator's S 7503 Surratts RD 31. Date filed (Month, Day, Year) JUN 21

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

Clinton, Maryland 20735

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2007 Month **Physician** 3:58 A M Roberta Louise Clark 26, June /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Allegany Frostburg Frostburg Village Nursing Home 8. Date of Birth May 22, 1938 If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🖫 F 218-80-7575 Maryland 69 Director Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. fnside City Limits 10b. County 28a-f show Exeminar must be notified at MD. Allegany Westernport 1 ☐ Yes 2 X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 21562 United States 23718 Stoney Run Road Iteme 23a Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11, Marital Status Black, White, etc. 1 Never Married 28 Married Specify: White Baltimore, Maryland 21215-0036 ò 1 ☐ Yes 2X No Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates. "netural", 27 is marked other than "neture traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Housework if Health and Mental Hygiene. item 27 is marked other than other traumatic event, the M Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Raymond Wilson Hazel McKenzie 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles J. Clark/ husband 23718 Stoney Run Road, Westernport, Maryland 21562 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition permit. Pages 1 Department of H Important: if ite any injury or ot ance. 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State LaVale, Maryland Rest Lawn Mem. Garden 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Boal Funeral Home ayon 111 Church St., Westernport, Maryland 21562 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death heart Failure fmmediate Cause (Final disease or condition resulting in death) ongestive Physician months /Medical Due to (or as a consequence of) emic Cardionyopathy Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran Due to (or as a consequence of): Box 68760. Physician/Medicai the as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown à peubis Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. Completed by 1 Yes 2 No 3 Probably 4 Nnknown peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has , page 2 autopsy performed 1 Yes 2 No Division of Vital director, Be 25. Was case referred to medical 26. Place of Death | Check on v one examiner' Hospitaf: 1 ☐ Inpatient 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Natural 2 Accident 5 Pending in 24 hours area the Funeral Director: Aft 1 🗌 Yes 2 🗆 No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 24 ho To the Fune completely f (Check only one) the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 26 andliv 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

Dr. S L Sandhir,
31. Date filed (Month, Day, Year)
JUN 2 7

32. Registrar's Signature

200

48 Tarn Terrace, Frostburg, Maryland, 21532

#### **Physician** June Sarah G. Collins /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BERLIN NURSING AND REHAB. CENTER BERLIN If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days Hours 1 □ M 2 🗓 F 213-16-8007 SEP 10,1921 Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10a. State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at MARYLAND WORCESTER BERLIN Director 10f. Zip Code 10e. Street and Number 1138 STEAM MILL HILL 21782 Pages 1 and 2 should be filed within 72 hours after death venent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23s Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2X Married Collins, Sarah G. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. ₽ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DOMESTIC HEALTH CARE AIDE 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be SARAH JANE MORRIS SIMON LEONARD - Son ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Collins, 327 PENN ST., SALISBURY, MD. 21801-4021 JAMES R. LEONARD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Department of H Important: If ite any Injury or of 1 Burial 2 □ Cremation 3 □ Removal from State JUN 23,2007 CURTIS U.M.C. CEM. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signati of Funeral Service Ligenses 22. Name and Address of Facility WATSON FUNERAL HOME, P.O. BOX 125 MILLSBORO, DELAWARE 19966 Part1. Enter the disease, or comshock, or heart failure. List only s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final Physician Creeks notardingin disease or condition resulting in death) Due to (or as a consequence of):

/Medical Examiner

Examine physician and s the burial-transit Physician/Medical attending physical for use as the b signed by the a þ been si Be Completed s certificate has b irector, page 2 s director, Medical Certification; To this

Records, P.O. Box 68760.

Division or Vital

the Hospital or Attending Physician: The law requires that the death certificate be executed To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Af completely filled in by the fur State Registrar

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical examiner?

1 ☐ Yes

27. Manner of Death

1 Natural 2 Accident

3 ☐ Suicide

29a, Certifier

4 Homicide

21 No

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

1. Decedent's Name (First, Middle, Last)

23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death

Due to (or as a consequence of

Due to (or as a consequence of):

3 ☐ Ectopic pregnancy 5 ☐ Other (specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy 1□ Yes 2 No

28d. Describe how injury occurred

26. Place of Death (Check only one)

2. Date of Death

18

2007

BERLIN,

4c. County of Death

10g. Citizen of What Country?

UNITED STATES

16b. Kind of Business/Industry

14. Race - American Indian,

Black, White, etc.

Specify: BLACK

HEALTH CARE

20c. Location - City or Town, State

23d. Date of delivery

Month

23e. Did tobacco use contribute to the cause of death?

BISHOPVILLE, MARYLAND

Approximate Interval Between Onset and Death

Morit

WORCESTER

Time of Death

11:15p<sub>M</sub>

9. Birthplace (State or Foreign

MD

10d. Inside City Limits

1 ☐ Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death? death? 1 ☐ Yes 2 No

Day

Year

Other: Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Turch Island De 1994

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

reliston

JUN 2 1 2007

5 Pending Investigation

6 ☐ Could not be

determined

egistrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Lonnie Adam Collins 10:15 p M June 19, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Havre de Grace Harford Citizens Care Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Yea Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☑ M 2 ☐ F 235-30-9793 Yrs 82 Aug. Director 3, Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "naturel", or Iteme 23a or 28a-f ehow the Medical Examiner must be notified at 1 √ Yes 2 No Maryland Cecil Perryville Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 100 Greenway, Apt. No. 105 21903 U.S.A. filed within 72 hours after death 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 SAYes 2 No If Yes, Give Year or Dates: 1943 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: þ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Wilson Food Corporation Elementary/Secondary (0-12) College (1-4or 5+) Landover, Maryland Eight Years Plant Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental I Pages 1 and 2 should be Looney A. Collins Myrtle Frady 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Heatth ar
Importent: If item 27 Ie
eny in|ury or other trau Peggy Campbell (Daughter) 14C Owens Landing Court, Perryville, Maryland 21903 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Grandview Memory Gardens 06/23/07 Bluefield, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligarises Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** \_ oron an >104x5 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) The law requires that the death certificate be executed attending physicien and for use as the burial-transit Exam that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Month 4 Pregnant at time of death 5 Other (specify) P.O. ed by the a 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ۵ 1 Yes 2 No 3 Probably 4 Unknown Be Completed certificate has been s rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA 1 Yes 2 No his After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending death. 1 □ Yes 2 □ No 2 Accident investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft To the Funeral Di completely filled in 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29d. Date signed (Month, Dey, Year) wham 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) +IVA Muhain 220 Kammele 31. Date filed (Month, Day, Year) 32. Pogistrar's Signature State **JUN 2 1** Registrar 2007

07-04664 Rickey Coggins

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

,33		1-For State Certificate of Death Registrar	Reg. I	No. 9 (1)	7 9190
Physicia	in/	1. Decedent's Name (First, Middle,Last)	2. Date of Death Month Da	y Year	3. Time of Death
Medical Exami		• 00	June 18, 200	7	1455 hrs
· ·		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death MD. Route 193 @ Rt. 1  College Park		4c. County of Death Prince George	's
,			8 Date of Birth/N		
Funeral Director			January	MM/DD/YYYY) 9. Birt Foreig	Griffin
	-	254-02-0886 1	panuary	0 1930	<sup>Intry)</sup> Georgia
any		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
<b>À</b> ,,	ايا	Maryland Prince George's Glenn Dale			1 Yes 2 No
Aaryland 28a-f show 1 at once.	Director	10e. Street and Number 10f. Zip Code	10g.	Citizen of What Cour	itry?
with the Maryland ms 23a or 28a-f sho be notified at once.		9820 Locust Street 20769	U	nited Stat	es
with ms 23	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spender) 14. Never Married 2. X Married Armed Forces? 15. Was Decedent of Hispanic Origin? (Spender) 16. Never Married 2. X Married Armed Forces?	ecify Yes or No-	14. Race - Ameri White, etc.	can Indian, Black,
death:	Fu	1 X Yes 2 No	, , , , ,	379 F	a ck
s after ral".	à	3 Widowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work)	ork done 116	Specify: B18  Sb. Kind of Business/I	
hour "natu	ted	Elementary/Secondary (0-12) College (1-4 or 5+)		D. Killa of Basillossi	industry .
136 hin 72 e. than edical	ed l	12 4 US Postal Worker	U	S Governme	ent
215-0036 be filed within 7 hatal Hygiene. rked other than ent, the Medica	Completed	17. Father's Name (First, Middle, Last)  18. Mother's Name (			
218 be fill ntal H rked	Be		Coggins		
more, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland ten of Health and Mental Hygiene.  unt: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once	မ	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or Ru			
MD and 2 she alth and 27 is		Diane Graham Coggins/ Wife 9820 Locust Street, G1  20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	enn Dale	MaryLand Oc. Location - City or	1 20/69 Town, State
Baltimore, permit Pages I a Department of He Important: If ite		1 XBurial 2 Cremation 3 Removal from State crematory or other place)		•	
timent trant:		4 Donation 5 Other Specify.		Cheltenha	
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural". injury or other traumatic event, the Medical Examiner.		21. Signature of Funeral Segrice Licensee  22. Name and Address of Facility Pop 5538 Marlboro Pike,			20747
Physician		23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or			Approximate Interval
/Medical		failule. List only one cause on each line. Immediate Cause (Final disease a. Multiple Injuries			Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	-		
		Sequentially list conditions, b.			
	ine	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause			
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x 68 h certi tendin use a	ician	nast 12 months?			
Box 687  ne death certific  r the attending 1  hed for use as ti	Physicia	1 Yes 2 No 9 Unknown g Unknown			
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Records, P.O. The law requires that th cate has been signed by page 2 should be detach			I 24a. Was an		utopsy findings available
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Division of Vital Records, P.O. Ital or Attending Physician: The Law requires that the face death. After this certificate has been signed by led in by the funeral director, page 2 should be detacted.		27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Pay Year) 1 Natural 5 Pending 28b. Time of Injury 28c. Injury at Work? 1450 hrs 1 Yes 2 ✓ No	28d. Describe how Driver auto au		
SiOf Mtenc death death sctor:	catic	2 Accident Investigation   1 Yes 2 No	28f Location (Str	eet and Number of Ri	ural Route Number, City
Divis al or A s after al Direct	Certification:	3 Suicide 6 Could not be determined (Specify) Major Road / Highway		e) DRt. 1, College Pa	
Division of Vital Records, P.O. B within 24 hours after death.  To the Hospital or Attending Physician: The law requires that the d within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached					
To the II within 24	Medical	(Check only one)  2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at	t the time, date an	d place, and due to the	ne cause(s)
To wit To con	Mec	and manner stated.  29b. Signature and title of certifier  29c. License number		29d. Date signed (Mo	
01		Quoto O.C.M.E.		June 19, 2007	
183	1	30. Name and address of person who completed cause of death (Item 23a)			
		Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	<u> </u>		
	tate				
Regis	trar	Mary N. Palar			

DHMH 17 Rev 1/2001 OCME 2006

State of Maryland / Department of Health and Mental Hygiene Amended#10c & **1**- State Registrar 19b, 6/28/07, M.S. Kent Co. Certificate of Death Reg. No.C 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Day **Physician** Elwood James David Sr. 20 2007 1805 6 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Elkton FUnder 1 Year Ionths Days Union Hospital Cecil 8. Date of Birth (Month, Day, Year) 03-22-1930 If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday 5. Social Security Number 6 Sex **Funeral** Min Months Hours 1₽M 2□F 222-12-6838 77 Vrs Delaware Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County itam 27 is marked other then "natural", or Items 23s or 28s-1 show other traumatic event, the Micrical Examinar must be notified at 1 ☐ Yes 2 ☐ No Earleville Director MD Ceci1 Crystal Beach 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 34 5th Avenue 21919 IISA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1X Yes 2 No If Yes, Give Year or Dates: 49-52 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: white Specify: δ 3₺ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) passenger service railroad 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William David Edna Elizabeth Wright 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 34 5th Avenue Crystal Beach, MD 21919 Earleville Edna Wallace-daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State 6-26-2007 Gracelawn New Castle, DE 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fellows, Helfenbein & Newnam 21. Signature of Funeral Service Licensee 130 Speer Road Chestertown, MD 21612 uk 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): 1204 Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner nding physicien and use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant After this certificate has been signed by the atten funeral director, page 2 should be detached for u 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 3 ☐ Probably 4 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autons performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 200 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 🗌 Yes 2 No 2 ER/Outpatient 3000A 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 27. Manner of Death 28d. Describe how injury occurred Injury 1 Natural 5 Pending To the Hospitel or Attending within 24 hours effer death.

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 29a. Certifier 🛮 🗀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) dertifier 29c. License number 29h Signature and little d 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BON SMeet + TSRUK UBRAMO 31. Date filed (Month, Day, Year) 32. Registar's Signature State 25 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amended #4b,6/20/5tate Registrar State of Maryland / Department of Health and Mental Hygiene MS., Kent Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 12 11W **Physician** eisro. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Perryville Parkville

| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 11-24-1913 Oak Crest View Nursing Facility
7. Age (In yrs. last birthday) Baltimore Birthplace (State or Foreign Country)
 PA 5. Social Security Number (In yrs. 93 **Funeral** 1 □ M 2 □XE Yrs. Director 161-07-1995 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State r 28a-f show notified at 1 □ Yes 2 □ No MDBaltimore Baltimore **Funeral Directon** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö must be 'natural", or items 23a 8820 Walther Blyd death \ 21234 USA Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married white 1 ☐ Yes 2 No Maryland 21215-0036 Specify Specify: þ 3 □Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary Stee1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Philip Speer Young Elizabeth Martin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 500 Barksdale rd, Joppa, MD 21085 Charles Deisroth- nephew Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Pauls 6-14-07 Chestertown, MD 22. Name and Address of Facility Fellows, Helfenbein & Newnam 21. Signature of Funeral Service License Kick of 130 Speer Rd. Chestertown, MD 21620 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Lune /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: esn. 23c. If yes, outcome pf pregnancy
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2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only and manner stated. 29b. Signature and title of certifier 0 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2800 MUCE

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

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DHMH 17 Rev 1/2001

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	TH		30. Name and address of person who	completed cause of deat	h (Item 23a) (Typ	e, Print)	11 1	01		1 2	ST	11	11	A TIM
	-		31. Date filed (Month, Day, Year)	32 Registrar's	Signature	iest [	tig	17 ×	· Dui	Tex	2	147	Man	1)2/16
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 12:53 A M 2007 JUNE 17, BARBARA K. FREEDMAN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 10902 GAINSBOROUGH ROAD POTOMAC MONTGOMERY If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Davs | Hours | Min. | (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 ☐ M 2 🔀 F 64 NOV 7, WASHINGTON, DC Director 577-56-9216 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County fshow iral", or items 23a or 28a-f show Examiner must be notified at 1X Yes 2 No MARYLAND MONTGOMERY POTOMAC Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 10902 GAINSBOROUGH ROAD 20854 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after a Hygiene. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No 2 Specify: 3 ☐ Widowed 4X Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) ACADEMIC THERAPIST **EDUCATION** permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 Is marked othe any injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be DOROTHY WEIMAN THEODORE KIRSCH ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BETH FREEDMAN/DAUGHTER 10902 GAINSBOROUGH ROAD, POTOMAC, MARYLAND 20854 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State JUDEAN MEMORIAL GDNS 06/19/2007 OLNEY, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service Licensee Signature 22. Name and Address of Facility
EDWARD SAGEL FUNERAL DIRECTION, INC.
1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 23a. Part1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician METASTATIC BREAST CANCER disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit Exam Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical as IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 🖾 No P.O. ed by the 9∏Unknown 9 ☐ Unknown signed by d 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown cate has been signated by page 2 should by Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1□ Yes 2√ No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home S Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 funeral 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? within 24 hours after death.

To the Funeral Director: After completely filled in by the funera Certification: Attending (Month, Day Year) 5 Pending investigation 1 🕅 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide the Hospital or within 24 hours a To the Funeral C 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of confier 29c. License number 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D.C. WASHINGTON, 20037 CLAUDINE ISAACS, MD GEORGE WASHINGTON UNIVERSITY HOSPITAL, 901 23rd ST, NW,

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

JUN 2 1 2007

			1 - For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment e <i>rtificate</i>			nd M	,	giene Reg. No.	007	1. 10	UU
			Decedent's Name (First, Middle, La.	st)						2. Date of Dea			3. Time o	of Death
	Physici /Medi		Waunieta Marie Fr	azee						June 2	24, Day	2007 Year	3:05	РМ
i	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, T	Town, or L	ocation of	Death		4c. (	County of Dea	ith	
			Cherry Hill Assis	ted Living		Accid	dent				Ga	arrett		
	Funeral Director		5. Social Security Number 6. S		e (In yrs. last birthday 71 Yrs.		1 Year Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day May 6,	1936	_ C	thplace (State ountry) yland	or Foreign
	DQ		Usual Residence of Decedent  10a, State 10b, County		10c. City, Town or L	onetics.							T404 1i4- 6	Na. diania
	e Marylan a-f show lifted at	ctor	MD Garrett		Accident	ocation							10d. Inside C	s 2 No
	vith the	Director	10e. Street and Number	7		10f. Zip 0					-	en of What Co	ountry?	
,	s 23e	rai	105 S. Main St.,			2152					USA			
320	De filed within 72 hours after death with the Maryland nat Hygiene.  all Hygiene.  d other than "natural", or items 23e or 28a-f show avent. It e Maucal Examiner must be notified at	by Funerai	11. Marital Status  1  Never Married 2  Married  3  Widowed 4  Divorced	12. Was Decedent I Armed Forces? 1 Tyes 2 Th If Yes, Give Year or Dates:		If Yes, special	fy Cuban,	Mexican, Specify:	in? (Spe Puerto f	cify Yes or No- Rican, etc.)		4. Race - Ame Black, Whit Specify:	te, etc.	
5	72 hou nature	Completed	15. Decedent's Ed (Specify only highest gra		16a. Dece	edent's Usual	Occupati	on ring most	of workin	10	16b. Kin	d of Business	Mhite /Industry	
_	- × //4	mple	Elementary/Secondary (0-12)	College (1-4or 5	)+)	e kind of work DO NOT use	e retired)	ring most	OF WOTKII	, g		•••		
	2 should be filed within and Mental Hygiene. is marked other than eumatic avent, It a M.	e Co	10 17. Father's Name (First, Middle, Last)		HOME	emaker	1	8. Mother	's Name	(First, Middle,		1 Home		
	Mental Mental arked o	To Be	Carl William Fraze	e. Sr.						Fratz	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	, a, ma, mo,		
<u> </u>	s 1 and 2 should f Health and Men ftem 27 is marke other treumatic	-	19a. Informant's Name/Relationship (		19b. Mail	ing Address (				Route Numbe	r, City or	Town, State,	Zip Code)	
Š	and 2 aith a 127 is er trei		Roberta D. Sisler	/Sister	P.O.	Box 7	, Acc	iden	t, M	D 2152	20			
baltimore,	permit. Pages 1 and 2 Department of Health a Importent: If Item 27 is any injury or other tre		20a. Method of Disposition 1   Raurial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specify		20b. Place of Disp cemetery, cre Zion Ceme		e of her place)			ate 7, 2007		ation - City or Cident		
חשור	permit. Departm Importe any inju		21. Signature of Funeral Service Licen	Terma	4					man Fun sville,		Homes 21536		
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E	Examiner				ovascula	ar acc	cide	nt					8 mon	ths
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		a consequence of):									
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00100	icate be executed physician and s the burial-transit	edical		d.			<b>=</b>							
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ב א	D C D	Completed								24a. Was a autops perform	med?	prior to death?	utopsy findings completion of c	available cause of
OI VIIAI		BeC	25. Was case referred to medical examiner?						of Death	(Check only or	(6)			
5 8	this call dire	2	1 ☐ Yes 🏞 No	Hospital: 1 Inpatie	nt 2 ER/Outpatie			4   Nuis	sing Hor	e 5 🗆 Reside	ence 6	xassi	sted 1	Livi
	After Tune	ation:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation		y Year) 28b. Time o	of 28	c. Injury a Work? 1  Ye	t s 2 □ N		8d. Describe h	ow injury	occurred		
7 3	s after death	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju- building, etc	ury - At home, farm, st c. (Specify)	reet, factory.	office		2	8f. Location (Si City or Town	reet and n. State)	Number or Ru	ural Route Nun	nber,
- Indiana Laboration	ne nospiral of n 24 hours afte ne Funeral Dire bletely filled in t	Medicai (	29a. Certifier (Check only one)  (Check only one)  XI Certifying Physical Example (Check only one)	ysician: To the best of liner: On the basis of and manner sta	of my knowledge, dear examination and/or in ted.	th occurred at evestigation, in	t the time, in my opin	date and ion, death	place, a	nd due to the c d at the time, d	ause(s) a ate and p	ind manner as place, and due	s stated. to the cause(s	s)
4	within 2. To the F	ž	29b. Signature and title of certifier	0125			License n			2	9d. Date	signed (Mont	h. Day, Year)	
ŀ			- Etwark X	( CM Kinds	1	100	,,,,	_			06	25-20	0.7	

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUN 2 8 2007

32. Registrar's Signature

Physicia			State of Man per dr., 8871	Cer	lilicate o	Deam			
	n	Decedent's Name (First, Middle, Last,	)				2. Date of Dea Month		3. Time of Dea
/Medica	al	Dolly Virgini		21	<del>.</del>		June 20		10:15P
Examine	er	4a. Facility Name (If not institution, give Oakland Nursing a		ntor		, or Location of Dea	ath	4c. County o	
uneral		5. Social Security Number 6. Sec		n yrs. last birthday)	If Under 1 Ye		s. 8. Date of Birth	1	rett 9. Birthplace (State or Fo
rector		212-38-6184	]M 2∱2]F 9	O Yrs.	Months Day	rs Hours Mi	6/19/1	(, Year)	Country) Maryland
>		Usual Residence of Decedent  10a, State 10b, County							
oho a	5	,		Oc. City, Town or Lo	cation				10d. Inside City L 1 ☐ Yes 2
286-1	ect	MD Garrett  10e. Street and Number		Oakland	10f. Zip Code			10g. Citizen of W	
5		706 E. Alder St.				21550		USA	nat Country?
me 2	Funeral Director	11. Marital Status	12. Was Decedent Eve		Was Decedent of	f Hispanic Origin?	Specify Yes or No-		- American Indian,
- 1	2	1 ☐ Never Married 2 ☐ Married 3 🙀 Widowed 4 ☐ Divorced	Armed Forces? 1  ☐ Yes 2  ☑ No If Yes, Give Year or Dates:		lfYes, <i>s</i> pecify C 1□Yes 2 <b>X</b> N	uban, Mexican, Pue lo <i>Specify:</i>	orto Rican, etc.)		White, etc.
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e ven	Be	17. Father's Name (First, Middle, Last)				18. Mother's N	ame (First, Middle,		)
natio	2	Emory Frank	Elliott	10) 11 5		Mary	Cathe		Piefer
7 ls n traun	1	19a. Informant's Name/Relationship (Ty Walter Trout/ Son	pe, Print)		-		Rural Route Numbe Glen Burn		
other	-	20a. Method of Disposition	2	20b. Place of Dispo	A commence of the second secon				City or Town, State
Y or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ P 4 ☐ Donation 5 ☐ Other (Specify)	ionioval noin state	cemetery, crem Underwood					
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	Physici	ian	1. Decedent's Name (First, Middle, L William Leslie								2. Date of Month		Day	Year	3. Time of	
	/Medi	cal			.1		45 0% 7	-	1	-1 0	June	19		007	9:35	A M
	Examir	ner	4a. Facility Name (If not institution, gi 8628 Liberty Roa		)		•	own.or deri	Location of	or Death				ty of Death ederi	ck	
	Funeral				ge (In yrs. last b	oirthday)	If Under	1 Year	ff Under	24 Hrs.	8. Date of	Birth		9. Birthi	place (State o	or Foreign
	Director		212-38-2113	1 <u>1</u> 2∏ M 2□ F	66	Yrs.	Months	Days	Hours	Min.	8. Date of (Month, Jan.	15,	1941	Mar	yland	
	pu .		Usual Residence of Decedent		10. Oh. T.											
	anyla shov	ž	10a. State 10b. County		10c. City, Tov										10d. Inside C 1 ☐ Yes	•
	28a-1	ect	Maryland Freder  10e. Street and Number	ick	Fre	deri	10f. Zip	Codo				100	Citizon	f What Cou		
	with with	۵	8628 Liberty Road	4				1701						d Sta		
	72 hours after death with the Maryland natursi', or itsms 23s or 28s-1 show dical Exponer roust be notified at	Completed by Funeral Directo	11. Maritaf Status	12. Was Deceden	t Ever in U.S.	13. W				gin? (Spe	cify Yes or Rican, etc.)	1	14. Ra	ace - Ameri	can Indian,	
9	or its	교	1 Never Married 2 Married	Armed Forces	No	1					Rican, etc.)			ack, White,	etc. ite	
93	rei',	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			☐ Yes 2	LXINO	Specify:				Spec	ity: WII	116	
5-	"natu	ete	15. Decedent's E (Specify only highest g		168	a. Decede	ent's Usua and of wor O NOT us	l Occupa k done d	tion uring mos	t of workii	ng	161	o, Kind of	Business/Ir	ndustry	
12	withir than	Ę	Elementary/Secondary (0·12)	College (1-4or			enter						Cons	truct	ion	
<b>d</b> 2	filed Hygid other	S	17. Father's Name (First, Middle, Las	it)	` \	carpe	SIICEL		18. Mothe	er's Name	(First, Mide	die, Mai				
Maryland 21215-0036	iges 1 and 2 should be filed within 72 hours after death with the Marylan nt of Heelth and Mental Hygiene.  If item 27 is marked other than "naturs!, or items 23s or 28a-1 show or other treumatic event, the Marical Examiner must be notified as	To Be	Bernard A. Feez	er					Ma	rie I	. Bur	kha	rdt			
ary	shou and M	-	19a. fnformant's Name/Relationship	(Type, Print)	19	b. Mailing	g Address	(Street a	nd Numbe	er or Rura	l Route Nur	nber, C	ity or Tow	n, State, Zij	Code)	
	and 2 selth a n 27 i		Barbara A. Boone	/ Daughte	r P.	.o. I	Box 2	81,	Bucke		wn, M	D 2	1717			
ore	of He		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3	☐Removal from State		ery, crem	atory or ot	her place		D June	ate 20			- City or T		
Ë	Pag tment tant: jury o		4 □Donation 5 □ Other (Spec	ity)	Resti		n Cre		Ly	20	07				Mary1a	and
Baltimore,	permit. Pages 1 and 2 s Department of Heelth ar important: If Item 27 is any injury or other treu <u>pnce.</u>		21. Signature of Fundamental Service Lice	ense											P.A. 21701	
			23a. Part1. Enter the disease, or cor shock, or hear faifure. List on	ndications that cause one cause on each	od the death. Do	not ente	r the mode	of dying	, such as	cardiac o	r respirator	y arrest,			Approximat Interval Bet	ween
	Physician		Immediate Cause (Final disease or condition	-a Lu	ma C	a	ce	-						-	2 moset and l	itle
1	/Medical Examiner		resulting in death)	Due to (or a	s a consequence											
Н		9	Sequentially list conditions,	b. — Due to (or a	a ecraequanea	a offi						-				
	uted d ansit	듵	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	·		7.										
oʻ	exec en an	Exa	resulting in death) Last	c. Due to (or a	s a consequence	e of):										
8760,	The law requires that the death certificate be executed sie hes been signed by the ettending physicien and page 2 should be detached for use as the burial-transit	Physician/Medical Examiner		_ d												
9	ing ph	Med	IF FEMALE:													
Box	eath certific ettending pl	lan/	23b. Was decedent pregnant in the past 12 months?		2 Fetal deat		Ectopic pre							ate of defiv		Year
o.	that the de ned by the e detached (	yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4⊟ Pregnant a 9□ Unknown	at time of death	5□	Other (spe	ecify)				-				
۵	that t		Part II. Other significant conditions	contributing to death	but not resulting	in the un	derlying ca	ause give	n in Part I.		23e. Di	id tobac	co use co	ntribute to t	he cause of c	leath?
rds	quires n sign	d by									ij	Yes	2 🗆 No	3 Pro	bably 4 □l	Jnknown
000	law requir ss been si 2 should l	Completed									24a. W	as an	24b	. Were auto	opsy findings	available
R	The lay	E										itopsy informed s 2 <b>≥</b>		prior to co death? 1 \( \text{Yes}	empletion of a 2 No	ause of
ital	icisn: Th certificete rector, pag	Be C	25. Was case referred to medical examiner?				-		26. Place	of Death	Check on				24	
<u>&gt;</u>	Physicisn: r this certific ral director,	2	1 Yes 2 No	Hospital: 1  Inpat	ient 2 ER/O	Outpatient			4 🗆 140	ırsing Hon	ne 5 R	esidenc	e 6 🗆 O	ther (Speci	fy)	
0	ding P. After ti funera		27. Manner of Death 1 ★Natural 5 □ Pending	28a. Date of Inj (Month, D	ay Year) 28b.	Time of Infury		Bc. Injury Work			8d. Ďescrit	e how	infury occu	urred		
Sio	Attending ir death. sctor: After by the fune	cat	2 Accident investigate 3 Suicide 6 Could not	he -			М		'es 2 □		04 1 1'-					
Division of Vital Records,	after death. Dirsctor: A	Certification;	4  Homicide determined	d 286. Place of it	njury - At home, f etc. <i>(Specify)</i>	iarm, stre	et, factory,	office		2	City or			noer or Hur	al Route Num	1007,
	spital lours narsi filled		29a. Certifier 1 Certifying P	hysician: To the bes	t of my knowledd	ne. death	occurred a	at the tim	e. date an	d place, a	and due to t	he caus	e(s) and n	nanner as s	stated.	
	To the Hospital or Attending Physicien: The Within 24 hours after death.  To the Funars! Director: After this certificete hy completely filled in by the funeral director, page	edical	(Check only 2 Medical Exa	miner: On the basis and manner s	of examination a	ind/or inve	estigation,	in my op	inion, dea	th occurre	ed at the tim	e, date	and place	, and due t	o the cause(s	;)
	To the vithin To the comp	Me	29b. Signature and title of certifier				29c.	License	number	11	`	29d.	Date sign	ed (Month,	Day, Year)	-
•			Kenn	~	in	20	1	) 4	118	66		Ju	ne 19	, 200	)7	
	3		30. Name and address of person who									-				
	)		Kanan H. Hudhud,	M.D. 46 B	Thomas	John	nson	Dr.,	Fre	derio	ck, MI	21	702			
	Sta Registr		31. Date filed (Month, Day, Year)	2007 32. 100 is	trar's Signatus	A	ريهو									

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Maryland / Department of Health and Mental Hygiene	Con	10	5 1	

			For State Registrar		State of	Marylan				lealth Death		lental Hy	gien Reg. N		) () ]	4101
	100			ne (First, Middle, La	ast)							2. Date of D				3. Time of Death
	Physic			icia Ann								Month June	Da 1.8		Year 2007	12:39 рм
W.	/Medi			(If not institution, gi		ner)		4b. City	/. Town. or	r Location	of Death	0 0110			of Death	
J.	Exami	ier		ly Cross Ho		,		,		r Spr				Me	ontgom	erv
-	Funeral		5. Social Security I			. Age (In yrs.	last birthday)		er 1 Year	If Under	24 Hrs.	8. Date of B	irth		9. Birthp	lace (State or Foreign
	Director		176-34-4		1□M 2⊠F	65	Yrs.	Months	Days	Hours	Min.	(Month, E			Coun	ntry) sylvania
			Usual Residence of									1 CDI GGI	, 1,	17.12		o y i v ani i a
	yland <b>iow</b> at		10a. State	10b. County		10c. City	, Town or Lo	cation							1	0d. Inside City Limits
	Mar -fst fied	tor	Maryland	Prince Ge	eorge's				L	aurel						1⊈Yes 2 No
	r 28a noti	irec	10e. Street and Nu	ımber				10f. Z	ip Code				10g. C	itizen of	What Cour	ntry?
	3a o	D D	7700	Cherry Lar	ne. #204					2070	7			1	U.S.A.	
	ms 2	Funeral Director	11. Marital Status		12. Was Deced	ent Ever in U.	S. 13.	Was Dec	edent of H	ispanic O	rigin? (Sp	ecify Yes or N Rican, etc.)	0-		ce - Americ	
(0	or ite	Ē	1 ☐ Never Mar	ried 2 Married	Armed Force	X No	1					Hican, etc.)			ck, White,	etc.
8	urs a al', o Exan	by	3 🗆 Widowed	4 🛛 Divorced	If Yes, Give Year or Date	es:		1 ☐ Yes	212 No	Specify	:			Specif	y:	Black
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any loury or other traumatic event, the Medical Examiner must be notified at once.	Completed	(Spe	15. Decedent's E	ducation ade completed)		16a. Dece	dent's Us	ual Occup	ation during mo	st of work	ina	16b. l	Kind of B	usiness/Ind	dustry
7	thin an " Mec	nple	Elementary/Sec		College (1-4	lor 5+)				during mod d)		<i>g</i>				
2	er th	Con			4 +	•	Sci	ence .	Resour	ce Tea						Education
p	al H toth	Be (	17. Father's Name	(First, Middle, Las	t)					18. Moth	er's Nam	e (First, Middl	e, <i>Maid</i> e	n Surnar	ne)	
la	Ment Ment arked attc e	Z L		James Mo	:Coy						Ro	sie Moon	re			
ar	sho and sum		19a. Informant's N	Name/Relationship	(Type. Print)		19b. Maili	ng Addres	ss (Street	and Numb	er or Rui	a <i>l Route Num</i>	ber, City	or Town	, State, Zip	Code)
≥,	and salth		Kathleen	Ayiku - Co	ousin						NE, Wa	shingtor	n, D.(	C. 20	0018	
Se	es 1		20a. Method of Dis	sposition Cremation 3 [	The married from St	20b. P	lace of Dispo emetery, cre	osition (Na matory or	ame of other plac	ce)		Date	20c. L	ocation	- City or To	own, State
Ĕ	Pag nent int: II			5 ☐ Other (Spec		ate	. Carme			1	6/29	/2007	Pitt	sburg	h, Pen	nsylvania
Baltimore,	mit. partn <b>sorts</b> / Inju		21. Signature of 1	uneral Service Lice	nsee		2	2. Name a	and Addre	ss of Facil	ity					
m	o a E o		15	Ma	1		1	ines-1 1800	Kinaid New Ha	n Fune mpshii	erai i ce Ave	lome, Indenue, Sil	lver S	Spring	g, Mar	yland 20904
	70.00		23a. Part1. Enter	the disease, or cor art failure. List onl	nplications that cau	used the deatl	n. Do not en	ter the mo	ode of dyir	ng, such a	s cardiac	or respiratory	arrest,			Approximate Interval Between
	Physician		Immediate Cause	(Final			etowa E	of lux	•							Onset and Death
)	/Medical		disease or condition resulting in death)	on 🗸	a	e Respir rasaconsequ		allur	e						-	4 days
	Examiner					onary Hy		ion								vears
		er	Sequentially list control if any, leading to incause. Enter Und Cause (Disease of that initiated event)	onditions, mmediate		r as a consequ		1011							-	yeare
	uted d ansit	Examiner	cause. Enter Und Cause (Disease o	lerlying r injury	c Seps	ic										
,	icate be executed physician and s the burial-transit	Exa	resulting in death)	Last	V	r as a consequ	uence of):									
68760,	e be	Sal		•	d											
.89	ficate g phy is the	edical			- 0.											
Box	leath certifica attending ph I for use as t	Physician/M	IF FEMALE: 23b. Was deceder	nt pregnant	23c. If yes, outco	ome pf pregna	ancy							23d. Da	ate of delive	ery
m	death atte	cia	in the past 12	2 months?	1∐Live bir 4∐Pregna	th 2□Feta nt at time of d	l death 3L eath 5[	⊒Ectopic ⊒Other <i>(t</i>	pregnancy specify)	/					onth	Day Year
P.O.	the c y the ichec	ıysi	9 Unknow	n lvo	9□Unknov											
	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transition.		Part II. Other sign	ificant conditions	contributing to dea	th but not resi	ulting in the u	nderlying	cause giv	en in Part	I.	23e. Did	tobacco	use con	tribute to th	he cause of death?
sp.	uires sigr ld be	d by										1 🗆	]Yes	2□ No	3 🗌 Prob	ably 4. Unknown
Records,	w requ	Completed										24a. Wa	e an	24h	More oute	ppsy findings available
Re	has be 2	ш										aut	opsy formed?	240.	prior to co death?	mpletion of cause of
<u></u>													2 <b>⊠</b> N	0	1 ☐ Yes	2□ No
Vital	Physician: The la this certificate has ral director, page 2	Be	25. Was case refe examiner?		Hospital:				Oth		e of Deat	h (Check only	one)			
0	this al dir	잍	1 Yes 2		I A IN		ER/Outpatie		JUA	4 ⊔ N	ursing Ho	me 5 Res				fy)
		on:	<ol> <li>Manner of Dea</li> <li>Natural</li> </ol>	5 Pending		Day Year)	28b. Time of Injury		28c. Injur Wor			28d. Describe	now inji	ury occui	rred	
Sic	r Attending er death. rector: After by the fune	cat	2 ☐ Accident 3 ☐ Suicide	investigation 6 □ Could not l	0	& ladines - And		M facts		Yes 2	JIVO	001 1	(0)	- 4 - 1		(Death 1)
Division	l or Atten after death Director: I in by the	Certification:	4 ☐ Homicide	- data series a	, 28e. Place o	f injury - At ho g, etc. <i>(Specif</i>	ome, rarm, st y)	eel, tacto	лу, опісе			28f. Location City or T			per or Rura	al Route Number,
	ospital of hours a numeral E		00= 0====	450-201			lad 1	ih a	al at the co		mad I:			-> -		
	o the Hospital ithin 24 hours a o the Funeral ompletely filled	Medical	29a. Certifier (Check only one)	2 Medical Exa	hysician: To the beaminer: On the bas	is of examina	wieage, dea ition and/or ir	n occurre	on, in my o	me, date a opinion, de	ina place, eath occu	and due to th red at the time	e cause( e, date a	s) and m nd place,	anner as s , and due to	stated. o the cause(s)
	o the Ho rithin 24 o the Fu ompletel	Мес	29b. Signature and	d title of certifier	and manne	stated.		2	9c. Licens	e number			29d D	ate signe	ed (Month	Day, Year)

Shailesh Sheth, M.D., Holy Cross Hospital c/o Kaiser Permanente, 1500 Forest Glen Rd, Silver Spring, MD 31. Date filed (Month, Day, Year) State JUN 2 1 2007 Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

32. Registrar's Signature

DHMH 17 Rev 1/2001

29c. License number

D52503

29d. Date signed (Month, Day, Year)

June 19, 2007

			1 - State Registrar	State of	Maryland	•	artmen tificate			ind M		giene Reg. No.	2007	21812
	Physici		Decedent's Name (First, Middle, Last)	Edith M	fargaret Ge	erley					2. Date of De Month Jun	ne 25, 2	2007 Year	3. Time of Death 2:15 P. M
	/Medic Examin		4a. Fecility Name (If not institution, give s Devlin M	reet and num		•	4b. City,	Town, or	Location o	f Death umber		_	County of Death	
	uneral irector		21.0/3/11	M 201F	7. Age (In yrs. la 89	ast birthday) Yrs.	If Under Months	1 Year Days	If Under a	Min.	8. Date of Birt (Month, Da June 1	y, Year)	9. Birth Cou	nplace (State or Foreign untry) Maryland
Maryland	a-f show	ctor	Usual Residence of Decedent  10a. State 10b. County  Maryland Alleg	any	10c. City	, Town or Lo	cation	(	Cumber	land				10d. Inside City Limits 1 ☐ Yes 2 No
th with th	23a or 28	ai Directo	10e. Street and Number 10301 Chris	tie Road	NE		10f. Zip	Code	21502	2		10g. Citiz	zen of What Coi	
G Z1Z15-UU36 filed within 72 hours after death with the Maryland Hydiane	rhen "naturel", or iteme 23e or 28e's show the Madical Examiner must be notified at	by Funerai	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	<ol> <li>Was Dece Armed For 1 Yes If Yes, Give Year or Da</li> </ol>	2 No		Was Deced If Yes, spec 1 ☐ Yes		spanic Orig n, Mexican Specify:	gin? (Spe . Puerto l	ecify Yes or No Rican, etc.)		I4. Race - Amer Black, White Specify:	
VIZIS-0036 within 72 hours af	then "natur he Madical	Completed by	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0·12)			16a. Dece (Give life.	dent's Usua kind of wor DO NOT us	k done d se retired	lurina mosi		ng	16b. Kir	nd of Business/I	ndustry Home
E 2 2	ed other	To Be Co	17. Father's Name (First, Middle, Last)	oseph Sig	gler				18. Mothe	r's Name	(First, Middle,	Maiden . Ruth L		
	I: If Item 27 Ie mark	-	19a. Informant's Name/Relationship (Type Ronald Gerley			1	-						Town, State, Z nd, Maryla	
Baltimore,	nt: If Item ry or othe		20a Method of Disposition  1 Burial 2 Cremation 3 R  1 Donation 5 Other (Specify)	emoval from S	State CE	ace of Dispo emetery, crer Cestlawn	natory`or o	ther plac		C	June 28, 2007	20c. Lo	cation - City or LaVale, N	
Daitin	Important: I eny Injury o once.		21. Signatur of Funeral Fervice Licens	Ski	M	22	2. Name an						Home P.A g, MD 215	
sxecuted [M]	sician and ledical aminer	al Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Liner Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (	or as a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence	pence of):	er the mod	e of dym	g, such as	cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
Geath certific	by the ettending physiached for use as the l	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	1 Live bi	come of pregnal irth 2  Fetal ant at time of de	death 3[	□Ectopic pa □ Other (sp					2	23d. Date of deli Month	ivery Day Year
US, T.	pe eq	ď	Part II. Other significant conditions con	tributing to de	ath but not resu	ulting in the u	nderlying c	ause give	en in Part I					the cause of death?
VICAN: The law requires that the	nis certificete has been si I director, page 2 should I	Completed		<i>'</i>							24a. Was auto perfo 1 \( \text{Yes}	osy omed?	prior to death?	atopsy findings available completion of cause of 2 \( \square\) No
DIVISION OF VITA Tor Attending Physician:	After the	tion; To Be	25. Was case referred to medical examiner?  1 Yes 2 No.  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date o	npatient 2 🗆 i	ER/Outpatier 28b. Time o Injury		8c. Injun Worl	er: 4 <del>⊡</del> Nu ⁄at	ırsing Ho	n (Check only one 5 ☐ Resi 28d. Describe	dence (	5 □Other (Spec	cify)
DIVISI	of Directors	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place buildir	of Injury - At ho ng, etc. (Specify	ome, farm, st	reet, factor	, office			28f. Location ( City or To			ural Route Number,
To the Hospital or	To the Funeral Directory filled in by	edicai	29a. Certifier 1 Certifying Physical Check only one)		best of my know asis of examinat ner stated.	wledge, deat tion and/or in	h occurred vestigation	at the tin	ne, date an pinion, dea	id place, ith occurr	and due to the red at the time.	cause(s) date and	and manner as I place, and due	stated. to the cause(s)
Tot	To the	Σ	29b. Signature and title of certifier	len			290	D C	o l l l	563		Jus Jus	place, and due te signed (Mont ユナバ	Duron
		3	30. Name and address of person who co	mpleted caus	e of death (Item	23a) (Type,	Print)	thy	.42	راء	ele	ウコ	2/3	To 1
	Sta Regist		31. Date filed (Month, Day, Year) JUN 2 9 2		egistrar's Signal	ture	Socie	J.						

			1- State of M State Amend PI line b-d, 23e, per Registrar	laryland/Dep r MD, g869 <sub>C</sub> 6	artment of Health a	and Mental H	ygiene	7 21813
			Decedent's Name (First, Middle, Last)			2. Date of 0	Death	3. Time of Death
	Physici /Medio		John Harold Geroski			June	24 2007	2325 M
1	Examir		4a. Fecility Name (If not institution, give street and number	)	4b. City, Town, or Location of	of Death	4c. County of D	
			Garrett County Memorial H	Hospital	0akland		Garrett	
	Funeral		*FIM 20 5	ge (In yrs. last birthday	) If Under 1 Year If Under Months Days Hours	24 Hrs. 8. Date of E Min. (Month, I	Birth 9. I	Birthplace (State or Foreign Country)
	Director			82 Yrs.	1.0	April		aryĺand
	and *		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or L	ocation			10d. Inside City Limits
	death with the Maryland rme 23a or 28a-f ehow rmust be codiffed at	5						1 ☑ Yes 2 ☐ No
	28a-	Director	MD Garrett  10e. Street and Number	Oakland	10f. Zip Code		10= Cisinon of Minos	21
	with	ā					10g. Citizen of What	,
	eath	Funeral	1113 Mary Drive	t Ever in II S 12	21550	-i-2 (Cit. V	United St	
_	iter d	Ľ	1 Never Married Married 1 Yes 21	?	Was Decedent of Hispanic Ori If Yes, specify Cuban, Mexican	gin? (Specity Yes or r i, Puerto Rican, etc.)	Black, W	merican Indian, hite, etc.
9500-6121	filed within 72 hours after Hygiene. kther than "natural", or ite ont, the Medical Examina	by F	3 Widowed 4 Divorced Year or Dates:		1 ☐ Yes 2 No Specify:		Specify:	hite
ş	2 hot	pe	15. Decedent's Education	16a. Dece	edent's Usual Occupation		16b. Kind of Busine	
2	n n	pie	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or	(Give	e kind of work done during mos DO NOT use retired)	t of working		
7	d with	Completed	Elementary/Secondary (0-12) College (1-4or	,	ervisor		Coal Min	e
<u> </u>		Bec	17. Father's Name (First, Middle, Last)		18. Mothe	er's Name (First, Midd	le, Maiden Sumame)	
yland	2 should be and Mental is marked o	To B	Jovo Durasevic		Ida	a B. Wilson	ı	
Mary	ges 1 and 2 should it of Health and Men if item 27 is marke or other traumatic	_	19a. Informant's Name/Relationship (Type, Print)	19b. Mail	ing Address (Street and Number	ar or Rural Route Nurr	ber, City or Town, State	a, Zip Code)
	and 2 saith a n 27 is		Sharon Porter, Daughter	1304	4 Alexander La	ne. Mtn. L	ake Park. M	D 21550
ē,	s 1 a f Hei item othe		20a. Method of Disposition	20b. Place of Disp	osition (Name of ematory or other place)	Date	20c. Location - City	
Saltimor	permit. Pages Deportment of the Important: If its any injury or of once.		1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	, ,	Memorial Gdns.	6/27/07	Oakland,	MD
	ortan ortan		21. Signature of Funeral Service Licensee				_	110
ä	Dep. Impo		* XaThianis (Mairie		2. Name and Address of Facility David A. Burd			F.O.
			23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each I	d the death. Do not en	21 N. Second	cardiac or respiratory	arrest.	Approximate
						and the dr. roopingtory	41.000,	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	reumonia	<b>7_</b>			1 Day
			resulting in death)					
	Examiner		Due to (or as	s a consequence of):	1: 0 /	1		< 20 years
		į.	Sequentially list conditions.	onte obstr	uctive pulm	onory di	's ease	20 years
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### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month <sup>Day</sup> 2007 June 16, 12:15 PM Ralph Edgar Gates 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Carroll Hospice Dove House Carrol1 Westminster If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. Birthplace (State or Foreign Months Days Hours Min. | Min. | June 15, 1929 | Maryland | Maryland 5. Social Security Number 7. Age (In yrs. last birthday) 12 M 2□F Months Days 78 218-20-2454 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 Yes 2 No Maryland | Carroll Mt. Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4244 Roop Road 21771 USA 14. Bace - American Indian. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 X Yes 2 □ No Black, White, etc. 1 Never Married 2 Married XYes 2 Yes, Give 1 ☐ Yes 2 X No Specify: Specify: 3 ₩idowed 4 Divorced Year or Dates: WW II White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Owner/Operator Towing Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ellen Gates Unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4291 Hollow Court, Middletown, MD 21769 <u>Sharon Jarels/Daughter</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Patuxent Cem Mt Carmel 6/21/07 Sunshine, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Stauffer Funeral Home, FA 8 E. Ridgeville Blvd, Mt. Airy, MD 21771 23a. Parri. Enter the disease, or conshock, or heart failure. List only aplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, y one-cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cerebovaschen disease or condition resulting in death) Due to (or as a consequence of): Aspiralmy if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Christic resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown

Physician /Medical Examiner

certificate be executed

Box 68760.

o.

۵.

**Physician** 

Examiner

**Funeral** 

Director

show

"natural", or Items 23a or 28a-f sh idical Examiner must be notified

traumatic event, the Medical

Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me one.

72 hours

filed within 7 Hygiene.

Pages 1

Baltimore, Maryland 21215-0036

Directo

Funeral

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Completed

Be

2

/Medical

burial-trans and physician sthe burial attending p use as the signed by to Id be detach peen cate has certificate

Examine

Division or Vital Records, or Attending Physician: this After thi funeral death. within 24 hours after death

To the Funeral Director:
completely filled in by the f Hospital

Physician/Medical Completed by Be 2 Medical Certification:

State

JUN 18 31. Date filed (Month

25. Was case referred to medical examiner?

5 Pending investigation

6 ☐ Could not be

determined

1 Yes 2 No

27. Manner of Teath

1 U atural

2 Accident

3 ☐ Suicide

29a. Certifier (Check only one)

4 ☐ Homicide

29b. Signature and title o

1 ☐ Inpatient

28a. Date of Injury (Month, Day Year)

29c. License number D-0054218

1 ☐ Yes 2 ☐ No

1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 06-18-00

28f. Location (Street and Number or Rural Route Number, City or Town, State)

24a. Was an

26. Place of Death (Check only one)

autopsy perform

Other: 4 Nursing Home 5 Residence 6X Other (Specify) Hospice

28d. Describe how injury occurred

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Malcolm dure, West minter MJ B Kanews, 349

32. Registrar's Signature

Registrar

2 ER/Outpatient 3 DOA

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician Day p № Harold Howard GIST, M.D. 24 2007 /Medical 1:14 June 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Homewood Nursing Home Williamsport Washington If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1**X** M 2□ F 92 Director 294-26-2787 March 15 1915 Missouri Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits items 23a or 28a-f show notlfied at Director 1 ☐ Yes 2 ▼ No Maryland| Washington Hagerstown 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? the Medical Examiner must be Funeral 20009 Rosebank Way USA Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. 21742 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 'natural', or 1 ☐ Yes 2 No þ 3 🕅 Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Physician Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be fi Department of Health and Mental H Important: If item 27 is marked ott any Injury or other traumattc ever 2 Emory Howard Gist Fannie Reser 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> Harold M. Gist - Son</u> 12007 Bayer Drive, Smithsburg, Md. 21783 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ▼Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown Crematory 6/27/07 Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home estas trid 415 E. Wilson Blvd. Hagerstown, Maryland 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) 7 PG /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence on Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) 9 Unknown contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1∐ Yes Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Certification: To 1 ☐ Yes 2 🔀 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c 28d. Describe how injury occurred After Injury at Work? 1 Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Director: within 24 hours at To the Funeral D

(Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and t

29c. License number

ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

completed cause of death (Item 23a) (Type, Print) Allen W Ditto, 13424 Pennsylvania

Ave Suite 101

WH-25+1 State Registrar

31. Date filed (Month, Day,

29a. Certifier

Medical

32. Registrar's Signature

and manner stated.

DHMH 17 Rev 1/2001

BA5-1

State Registrar acc

MD

Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 2 2007

07-04596 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Octavio Pascual State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Reg. No 1. Decedent's Name (First, Middle, Last) Octavio Antonio Pascual Guerra 2. Date of Death Physician/ Month Day June 16, 2007 **Medical Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 8116 15th Avenue Hyattsville 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Days Director Months Hours Min 02/18/1982 None 1 X M 25 2 Usual Residence of Decedent any 10a, State 10c. City, Town or Location s 23a or 28a-f show e notified at once, 28a-f show Md Prince George Hyattsville rect 10e. Street and Number 10f, Zip Code ä 8107 15th. Avenue 20783 Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or Nomust be Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Married . Or 2 X No Yes Widowed Divorced If Yes, Give Yea 1 X Yes 2 No specify: Guatemala or other traumatic event, the Medical Examiner þ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) t. Pages 1 and 2 should be filed within 72 rement of Health and Mental Hygiene. MD 21215-0036 6th Labor 17. Father's Name (First, Middle, Last) marked Be Francisco Antonio Pascual 19a. Informant's Name/Relationship (Type, Print ) Important: If item 27 is Josefa Antonia Pascual/Sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date Baltimore, 1 x Burial 2 Cremation 3 Removal from State crematory or other place) General Cemetery 06/26/07 Donation 5 Other Specify: 22. Name and Address of Facility 21. Signature of Funeral Ser **Physician** failure. List only one cause on each line /Medical a Multiple Sharp Force Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and transit Physician/Medical the attending physician a ned for use as the burial -UNPENDED χ A#F,DEPME,g869, 7/19/07 TT IF FEMALE: 23c. If yes, outcome of pregnar by 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) icate has been signed by the att page 2 should be detached for 1 Yes 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ρ Completed 24a. Was an autopsy this certificate has performed? ✓ Yes 2 director, 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner's Hospital: Inpatient 2 ER/Outpatient Nursing Home 5 3 1 Yes ဂ္ funeral After t 28a. Date of Injury (Month, Day, Year) FOUND: 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Natural FOUND: Yes 2 V No Pending Jun 16, 2007 0910 hrs 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 6 Suicide Could not be

4c. County of Death Prince George's 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Country) Guatemal 10d. Inside City Limits 1 X Yes 2 No 10g. Citizen of What Country? Guatemala 14. Race - American Indian, Black, White, etc. Specify: Hispanic 16b. Kind of Business/Industry Landscaping 18. Mother's Name (First, Middle, Maiden Surname) <u>Blanca Mirtala Guerra</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8107 15th. Ave. Hyattsville, Md. 20783 20c. Location - City or Town, State Guatemala Murray Funeral Home 4804 Georgia Ave. NW. Wash. DC 20011 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and Death Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. 23d. Date of delivery Year Day 23e. Did tobacco use contribute to the cause of death? Yes 2 ✔ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 V Yes No Residence 6 V Other: Scene 28d. Describe how injury occurred Certification: Subject stabbed and cut the Funeral Director: mpletely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 8116 15th Avenue, Hyattsville, MD determined (Specify) Parking Lot 4 Momicide 29a. Certifier 1 Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E June 17, 2007 ame and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 32. Registrar's Signature 31. Date fil 1 (1) 10 Day, 12 00 7 State Registrar

Time of Death

0913 hrs

DHMH 17 Rev 1/2001 **OCME 2006** 

OCME

**ORIGINAL** 

			For State Registrar		Marylan		artment of I tificate of			R	eg. No.	007	· ·	618	
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	/Medic	_	MARY	С.	HURLEY					JUNE	17,	2007	4:00	A M	
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			6500 OLD SANDY  5. Social Security Number 6. S		RD. 7. Age (In yrs.	last hirthday)	LAU If Under 1 Year		24 Hrs.	8. Date of Birth		NCE GE	ORGES place (State	or Foreign	
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	rylan how Lat		10a, State 10b. County		10c. City	y, Town or Lo	cation					1	10d. Inside C	*	
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	permit. Pages 1 and 2 should be flied within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I flem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number				10f. Zip Code				l 0g. Citizen	of What Cour	ntry?		
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ğ	w requires that the d been signed by the should be detached		CONGESTIVE HEART FAILURE							1 🗆 Y	1 Yes 2 No 3 Probably 4 Unknown				
Hecords,	2 3 2		BREAST CANCER							24a. Was an autopsy autopsy 24b. Were autopsy findings available prior to completion of cause of					
	sician: The certificate ha rector, page		ANEMIA performed? de 1 yes 2 No 1							death? 1 ☐ Yes	2□ No				
	Attending Physician: Thr death. ector: After this certificate by the funeral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			. — Ot			(Check only or			ASSIS	TANT	
ō	r Attending Physi fer death. irector: After this on the funeral direction	은	1 ☐ Yes 2 No  27. Manner of Death	1 □ Ir 28a. Date o	npatient 2  of Injury	ER/Outpatier 28b. Time of	it 3 DOA O	ırv at	ursing Hom	ne 5 ☐ Resid	ence 6 🗴	Other (Special	LI	VING	
Division or Vital	ding h. : Afte fune	Certification:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation  28a. Date of Injury 28b. Time of Injury 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No												
	or Attendater death		3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number,								mber,				
	i i i i i	erti	4 ☐ Homicide determined building, etc." (Specify) City or Town, State)												
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier  (Check only 2   Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									(s)			
	To the H within 24 To the F complete		one) 29b. Signature and title of certifier	and mann				se number				igned (Month,			
	Wil Col	-	250. Signature and the of certifier	11/11						· ·					
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)							18, 2	.007				
				S, M.D.			RY LA.,	LAURE	L, MD	. 20707	,				
	Sta	te	31. Date filed (Month, Day, Year)	32					لسد و د						
	Registr	ar	JUN 2 1 2	107	egistrar's Signa	J. 164	arti)								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland / Department of Health and Mental Hygiene 28b per dr., g8/0,08/16/07dhb Reg. No. 1 - State Registrar 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month **Physician** Richard  $p^{M}$ Hough 18, 2007 Lee 4:05 June /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Nov. 04, 1925 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F California 556-24-4465 81 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f sh notified Director 1X Yes 2 No Maryland Montgomery Bethesda 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? a or must b 6302 Orchid Drive 20817 United States Funeral items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. Examiner filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ☑ No Specify: <u>≨</u> 3 ☐ Widowed 4 ☐ Divorced Caucasian Completed permit. Pages 1 and 2 should be filed within 72 hr. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturany injury or other traumatic event, the Medical any injury or other traumatic event, the Medical. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Public Policy/ Foreign Service Officer/
Professor Elementary/Secondary (0-12) College (1-4or 5+) 5+ Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Lee Hough ဥ Kathyrn Hindinger 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edrie Hough / Spouse 6302 Orchid Drive, Bethesda, Maryland 20817 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Alexandria, VA Metropolitan Crematory 6/20/2007 22. Name and Address of Facility
Simple Tribute Funeral and Cremation Center
1040 Rockville Pike, Rockville, Maryland 20852 21. Signature of Funeral Service Licen 23a. Part1. Enter the disease, of conshock, or heart failure. List on plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death Immedia C. se (Final disease dition resulting in death) WP **Physician** REF dae /Medical Due to (or as a gensequence f) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence requires that the death certificate be executed Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? **Vision or Vital** 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Hospital or Attending 1 Natural 5 ☐ Pending investigation 9:30 A M 2 Accident June 13, 2807 1 Yes 2 No -all within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number City or Town, State) 302 0 child D 28f 4 ☐ Homicide 40ml Betersdamo 2081 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Mal 30. Name and address of pe son who completed cause of death (Item 23a) (Type, Print) MD Fernwood Rd., Bethesda, MD 10215 enningy O,

State Registrar 31. Date filed (Month, Day,

Year)

2

32 Registrar's Signature

			For State Registr <i>a</i> r	State of Mar		epartmer <i>Certifica</i> :			-	giene Reg. No. 4	007	21620
	Physici		1. Decedent's Name (First, Middle, La Elsie	st) J. Hawk	ins				2. Date of De Month June 13,	Day	Year	3. Time of Death 6:10 a <sub>M</sub>
	/Medic Examin		4a. Facility Name (If not institution, giv			4b. City	Town, or Lo	ocation of Death	ounc 15,		ounty of Death	
			Carriage Hill					nesda		M	Montgomer	_
3	Funeral		Social Security Number     6. S	ex 7. Age ( ☐ M 2X F	In yrs. last birti	Months		f Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th y, Year)	9. Birth	place (State or Foreign intry)
Art .	Director		577-14-8673 Usual Residence of Decedent		88	rs.			Septembe	r 22,19		rict of Columbi
	iand bw it		10a. State 10b. County	1	0c. City, Town	or Location					1	10d. Inside City Limits
	Mary -f she fled a	tor	DC		Was	hington						1 ☑Yes 2 ☐ No
	r 28a	Director	10e. Street and Number		wab	10f. Zij	Code			10g. Citizer	n of What Cou	intry?
	th wit	al D	125 North Carolina	Avenue, SE			200	003			U.S.A.	
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S.	13. Was Dece	dent of Hisp cify Cuban,	anic Origin? (Spe Mexican, Puerto	ecify Yes or No Rican, etc.)	- 14.	. Race - Ameri Black, White	
36	s afte ; or it	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 X No If Yes, Give		1 ☐ Yes		Specify:	,			31ack
2-0036	hour tural		3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Ed	Year or Dates:	16a	Decedent's Usu	al Occupation	on		16h Kind	of Business/Ir	
215	in 72 n "na n Aedio	plet	(Specify only highest gra	ide completed)	/17	(Give kind of wo life. DO NOT u	ork done dur se retired)	ing most of work	ing	TOD. KING	Of Dusiness/ii	luustry
	d withir giene. rr than the Me	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) 2	Ì	Account	ant			U.S.	Governme	ent
פ	e filed al Hygie other vent, th	Bec	17. Father's Name (First, Middle, Last,	)			18	8. Mother's Name	(First, Middle,	Maiden Su	ırname)	
<u>a</u>	Ments Ments arked	70	William Jacks	on			_	Amy	Lane			
Maryland	2 sho		19a. Informant's Name/Relationship (	Type. Print)	19b.	Mailing Address	(Street and	d Number or Rura	al Route Numb	er, City or T	own, State, Zi	p Code)
2 (i)	l and leatth im 27 her tu	- 8	Barbara A. Hammond -					Suitland,				
altimore,	ages 1 nt of h t: If ite		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Inemoval from State	cemeter)	Disposition (Na. ,, crematory or o	ne or other place)		Date	20c. Locat	tion - City or T	own, State
	it. Pa ntmer rtant njury		4 ☐ Donation 5 ☐ Other (Specification 21. Signature of Funeral Service Licer		Gate of	Heaven (		,	/2007	Silver	r Spring	, Maryland
n n	permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygie Important: If Item 27 is marked other trans any injury or other traumatic event, the once.	2 0	▶ amanda	Luduvia		Hines-R	inaldi	Funeral H	ome, Inc	ver Spr	ing, Mar	yland 20904
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused hone cause on each tipe.	e death. Do n	ot enter the mod	le of dying,	such as cardiac o	or respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Advanc	ed Colon	Cancer						Onset and Death
	/Medical Examiner		Todaling in dodain	Due to (or as a c	consequence o	f):						
		-e	Sequentially list conditions, if any, leading to immediate	b Due to (or as a c	consequence o	f):						
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events									
o	an an rial-tr		resulting in death) Last	Due to (or as a c	consequence o	f):		-				
09/89	ficate be executed physician and s the burial-transit	edical		d								
_	certifica nding planse as t		IF FEMALE:									
X P P	death certific e attending p	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf	Fetal death	3 ☐ Ectopic p				230	d. Date of deliv	very Day Year
o o	the de	Physician/M	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	4□Pregnant at tin 9□Unknown	ne of death	5 ☐ Other (s)	pecity)					,
ř.	w requires that the de been signed by the should be detached		Part II. Other significant conditions of	ontributing to death but r	not resulting in	the underlying o	ause given i	in Part I.	23e. Did t	obacco use	contribute to	the cause of death?
ecords,	quires n sign ald be	d by							1[]	Yes 2⊠i	No 3∏Pro	bably 4 Unknown
ပ္ပ	law red as bee 2 shou	Completed							24a. Was	an 2	24b. Were aut	opsy findings available
r	The lav	шо							autor perfo 1⊟ Yes	rmed?	prior to co death? 1 ∐ Yes	ompletion of cause of
	lan: ortifica ctor, p	Bec	25. Was case referred to medical examiner?				2	6. Place of Death		-	I 🗆 res	2010
0 0	Physiclan: r this certific ral director,	20	1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient	2 ER/Out	oatient 3 DC	Other:	4 Nursing Ho	me 5 Resid	dence 6	Other (Speci	ify)
	ding Physician: The n. After this certificate he funeral director, page		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Y	<i>'ear)</i> 28b. Ti		28c. Injury at Work?		28d. Describe I	now injury o	ccurred	
VISION	ttend death stor: /	cati	2 Accident investigation 3 Suicide 6 Could not be		At home for	M	_	s 2□No	200 1 11 11			
2	al or A s after or il Direct	Certification:	4 ☐ Homicide determined	building, etc. (	Specify)	n, street, factor	y, office		City or Tov	otreet and N vn, State)	lumber or Hur	al Route Number,
	To the Hospital or Attending Pi within 24 hours after death To the Funeral Director: After the completely filled in by the funeral	edical (	29a. Certifler (Check only one)  1 Certifying Ph 2 Medical Exam	yslcian: To the best of r niner: On the basis of ex and manner stated	camination and	death occurred for investigation	at the time, , in my opin	date and place, ion, death occurr	and due to the ed at the time,	cause(s) ar date and pl	nd manner as s lace, and due	stated. to the cause(s)
	To th Withii To th comp	Me	29b. Signature and title of certifier	ſ. I.		29	. License n	umber		29d. Date s	signed (Month,	, Day, Year)
			> Iliyai	nonvoler	$\vee$		D5336	57		June	15, 2007	
	10		30. Name and address of person who	-								
	-01		Shyamsundar Rajan, 31. Date filed (Month, Day, Year)					e 117, Si	lver Spri	ng, Ma	ryland 2	0912
	Sta Registra	-	JUN 2 1 2	32. Registrar's	J. Jr.	Aporte						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** a M 6:50 2007 June 19. Paul G. Haggerty /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Olney If Under 1 Year Montgomery General Hospital 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 24 Hrs. 7. Age (In yrs. last birthday) Social Security Number **Funeral** Months Days Hours 1 🙀 M 2 🗆 F Yrs Director 81 Dec. 8. Massachusetts 025-16-7699 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any one. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 No Directo Silver Spring Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20906 USA 15107 Interlachen Drive, #303 Completed by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ⊒Yes 2 No If Yes, Give WWII Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🖾 No Baltimore, Maryland 21215-0036 Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction Worker Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elizabeth A. Munro Patrick H. Haggerty ို 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 15107 Interlachen Drive, #303, Silver Spring, MD 20906 Anna M. Haggerty/Wife Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition June 25, 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2007 Silver Spring, Maryland Francis J. Collins Funeral Home Inc. 21. Signatu Funeral Service Licen 500 University Blvd, W., Silver Spring, MD 20901 Approximate Interval Between Onset and Death ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. 23a. Part 1. Enter the disease, or c shock, or heart failure. List o Immediate Cause (Final Physician -ongestive resulting in death) /Medical Due to (or as a consequence of): Examiner 10 years o ROMARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Sue to for es a consecillence of: Examiner sician and burial-transit requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If ves, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) ☐Yes 2☐No P.0. detached 9 Unknown signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 Aveni 1 certificate 1□ Yes Physician: director, 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient မ this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death e Hospital or Attending Pl 24 hours after death. e Funeral Director: After ti Certification: After Injury 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier BC1082039

6+1

State
Registrar

31. Date filed (Month, Day, Year)



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

fort

Prince Phillips Dr., Olney,

UND 21 \$32

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 12.30 P M Year Physician Marting Zew7 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Ellicott City Health & Rehab. Ctr. Ellicott City

If Under 1 Year | If Under 24 Hrs. Howard Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 07/12/1921 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Days Funeral 1 ☐ M 2 🛛 F South Carolina 85 579-20-7912 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State or 28e-f show Examiner must be notified at 1 ∑Yes 2 ☐ No Columbia Directo Howard 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Importent: if tiem 27 is marked other than "--- any injury or other treums". 238 21045 USA 8975 Footed Ridge Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify: 3 X Widowed 4 ☐ Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Healthcare RN/Midwife 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rosalee McWhirter Starks Kellv 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Philip Atkins/Grandson 7304 Rockridge Road Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Riverdale Park Crematory | 06/21/2007 Riverdale, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Montgomery-Cheatham Funeral 21. Signature of Funeral Service Licensee Jonya Montagomery Cheathan Service P.O. Box 388 Upper 23a. Part Litter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Service P.O. Box 388 Upper Marlboro, MD 20773 Approximate Interval Between Onset and Death shock, or heart failure. List only Cardio vas Calar A thero sclevolce Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Digorker Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Physician/Medical Examiner the Hospitel or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Hemen to Semile Due to (or as a consequence of) Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☒ No 4☐Pregnant at time of death 5 Other (specify) <u>P</u> the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, δ 1 ☐ Yes 2 ☐ No 3 Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐ No ို 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: After Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical The design of the desis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the date and place, and due to the cause(s) and manner stated. etely the within 7 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 D30641 June 20 2007 6 Cloud npleted cause of death (Item 23a) (Type, Print)
201-105 Rack River Much Road Rathmore Hayland 21201 30. Name and address of person completed cause of death (Item 23a) (Type, Print) Ramel Sabapathi 32. Registrar's Sig 31. Date filed (Month, Day JUN 2 1 2007 State Registrar

		_ FOF	partment of Health and M ertificate of Death	lental Hygieno	2007 21022		
Physicia	_	1. Decedent's Name (First, Middle, Last)  Lois A. Hoenstine		2. Date of Death	3. Time of Death 5:30 PM M		
/Medic Examin	200	4a. Facility Name (If not institution, give street and number) Heartfields Assisting Living	4b. City, Town, or Location of Death Frederick	40	4c. County of Death Frederick		
Funeral Director		5. Social Security Number  185-12-9216  6. Sex 1 M XXF  7. Age (In yrs. last birthda	Months Davs Hours Min	8. Date of Birth Month Day, Year May 8, 19	9. Birthplace (State or Foreign Pennisylvania		
Maryland -f show fied at	tor	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Maryland Frederick Frederic			10d. Inside City Limits 1 ☐ Yes 2 ☐ No		
with the 3a or 28s	al Director	10e. Street and Number 8016 Broken Reed Court	10f. Zip Code 21701	10g. Ci U •	itizen of What Country?		
IIS 8	To Be Completed by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  XX Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes A No If Yes, Give Year or Dates:	3. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2XXIo Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White		
within 72 hou iene. than "natura the Medical E		(Specify only highest grade completed) (Gillife  Elementary/Secondary (0-12) College (1-4or 5+)	cedent's Usual Occupation ve kind of work done during most of work a. DO NOT use retired) Co-Owner	Kind of Business/Industry neral Service			
ld be filed ental Hygi ked other ic event, t		17. Father's Name (First, Middle, Last) Lee Arnold	18. Mother's Name	e (First, Middle, Maide Shoop			
nd 2 shoul alth and M 27 is mari			ailing Address (Street and Number or Flur 5 Broken Reed Court				
Pages 1 a nent of Hea ant: If Item ury or othe		20a. Method of Disposition  1	position (Name of rematory or other place) k Cemetery June 26, 20		ocation - City or Town, State		
permit. Departn Importa any inju		21. Signature of Funeral Service Licensee  M00255	<sup>22</sup> Keeney and Address of Facility for 106 East Church St	d PA Funer ., Frederi	al Home ck, MD 21701		
Physician /Medical Examiner	Examiner	shock, or heart failure. List only one vause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	scelor struk	« C	Approximate Interval Between Onset and Death		
ate be physicia the bur	Physician/Medical Ex	d	3 □Ectopic pregnancy 5 □ Other ( <i>specify</i> )		23d. Date of delivery Month Day Year		
uires that the signed by the	þ	9 Unknown Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.		use contribute to the cause of death?		
2 a a	Completed			24a. Was an autopsy performed2 1∐ Yes 2 X N	24b. Were autopsy findings available prior to completion of cause of death?		
physician this certifi al director	To Be	27. Manner of Death 28a. Date of Injury 28b. Time	ient 3 DOA Other: 4 Nursing Ho	h (Check only one) ome 5 Residence 28d. Describe how inju	6XXother (SpecifyAssisted Livir		
	Certification:	1 Natural 5 Pending (Month, Day Year) Injur 2 Accident investigation 3 Suicide 4 Homicide determined (Month, Day Year) Injur 28e. Place of injury - At home, farm, building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)		
the Hospital or hin 24 hours afte the Funeral Dir npletely filled in	ledical Ce	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.	eath occurred at the time, date and place, r investigation, in my opinion, death occur	and due to the cause( rred at the time, date a	s) and manner as stated. nd place, and due to the cause(s)		
To the within To the compl	Me	29b. Signature and the occutifier  Hiron N 5666	29c. License number 05/64_3	_	ate signed (Month, Day, Year) une 22, 2007		
12		30. Name and address of person who completed cause of death (Item 23a) (Typ	Frederica	mp 2120	12_		
Sta Registr		31. Date filed (Month, Day, Year)  JUN 2 2 2007	Specie				

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Jume 18, 2007 11:47 P M Pamela Hyde Jones /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Clinton Southern Maryland Hospital 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day Year) Annual Page 1945 9. Birthplace (State or Foreign **Funeral** 127-36-0801 1 ☐ M 2 🛱 F California Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location Maryland Prince George's Fort Washington 1 ☐ Yes 2 No Directo 10g. Citizen of What Country? 10e. Street and Number 1801 Hollydale Road 10f. Zip Code 20744 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) 11. Marital Status Black. White, etc. 1 Never Married 2 Married Specify: White 1 Yes 2 No þ Specify: 3 Widowed 4 KNO ivorced Year or Dates: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Travel Elementary/Secondary (0-12) College (1-4or 5+) Travel Agent 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Kaufman Yvonne Donald Calvin Hyde 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1801 Hollydale Rd., Ft. Washington, MD 20744 19a. Informant's Name/Relationship (Type, Print) Richard A. Jones - Son 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Kalas Crematory June 20,2007 Edgewater, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Licenses George 1 de Karas Funeral Home, P.A. 6160 Oxon Hill Rd., Oxon Hill, MD 20745 Approximate Interval Between Onset and Death 23a. Part 1. Ever the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, in hear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the attending physicien and hed for use as the burial-transit Hospital or Attanding Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown s been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificete has autopsy performe 1 ☐ Yes To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 12 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e To the Funeral C critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated 29b. Signature and title of 9 29d. Date signed (Month, Day, Year) 29c, License numbe on who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Year 08:55 p M 6 0 2007 Kader Mushtaque /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Memorial Hospital Baltimore 9. Birthplace (State or Foreign Country)
India If Under 1 Year | if Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** 1**X** M 2□ F Nov. 6, Director 220-70-2669 60 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. inside City Limits 10b. County 28a-f show 1 Tyes 2 No the Medical Examiner must be notified Director Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or: 21225 303 Berlin Avenue United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No þ Specify Specify: Asian 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cashier Convenience Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Shaukat Kader Daw Khin Khin Gyi 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Liaquat Kader, Brother 4900 Cedar Garden Rd., Baltimore, Maryland 21229 or other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) MD Natl. Memorial Park June 20, 2007 Laurel, Maryland 21. Signature of Funeral Service Licenses Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Road, Beltsville, MD 20705 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final disease or condition resulting in death) **Physician** DAY Myolassdia /Medical Due to or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an performed' Division or Vital To the Hospital or Attending Physiclan: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | 1 No 1 thpatient 2 ER/Outpatient 3 DOA ၉ completely filled in by the funeral 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours after To the Funeral Dire 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Jaleed AT2438946 UNION 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WALEGO BOLAD 201 E. UNIVERSITY PARKUMAY. M.D. 32 Registrar's Signature 31. Date filed (Month, Day, Year) State JUN 2 1 2007 Registrar

State of Maryland / Department of Health and Mental Hygiene UU / 1 - State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 19<sup>Day</sup> 2007 Year рм June John Matthew Kane 8:45 /Medical Ctr 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Lutheran Village Health Care Westminster Carroll | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Day, Year) | Apr 21 1925 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**⊠**M 2□F 219-16-5467 82 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits or 28a-f show ir than "natural", or iteme 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director Westminster MD Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1000 Weller Circle USA Apt #109 21158 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1XYes 2 No 1943 filed within 72 hours after 1 Never Married 2K Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ If Yes, Give Year or Dates: Specify: Specify: 1945 White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Grief Brothers Sales Manager 10 Pages 1 and 2 should be filed w trans of Health and Mental Hygie tent: if Item 27 is marked other t ijury or other treumatic event, ID other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jerome Kane, Sr Julia Gruber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1000 Weller Circle Apt #109 Westminster, MD 21158 Frances Kane/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 06/26/2007 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Depertment Importent: If any Injury or gode. Garrison Forest Veterans Cem Owings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22 Printed Funeral Home and Chapel, P.A. 412 Washington Road Westminster, MD 21157 Inter the disease, or complication that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Betw Immediate Cause (Final disease or condition resulting in death) **Physician** lung can /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, but all cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine physicien and s the burial-transit law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical attending physic IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a o 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 3⊈ Probably 4 □Unknown 1 □ Yes 2 □ No Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? certificate 1 Yes 2 No of Vital 1 Yes 2 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 | Inpatient | 2 | EP/Outpatient | 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No this 28c. Injury at Work? After t Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Division 5 Pending investigation 1X Natural death. 1 ☐ Yes 2 ☐ No or Attend after death Director: / 2 Accident 6 Could not be determined To the Hospitel or Atte within 24 hours after de To the Funerel Directo completely filled in by the 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide Medical 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) abunswith MI) 51705 6-20-07 WI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Westminster, mp 21157 349 malwh m. PANSURIYA

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

**ORIGINAL** 

Glown & foods

32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month; Day, Year)

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			For State of M 1 - State Registrer	arytano		artment of #1 tificate of l	ealth and M Death		giené ( Rag. No.	07	21828
			1. Decedent's Name (First, Middle, Last)					2. Date of De. Month	ath Day	Year	3. Time of Death
	Physici /Medic		Icie Faye		ng			June	24	2007	0345 A M
	Examin		4a. Facility Name (If not institution, give street and number)				Location of Death			nty of Death	
			112 Red 1000 Rodu		ast birthday)	North If Under 1 Year	Last If Under 24 Hrs.	8. Date of Birt		ecil	lace (State or Foreign
Н	Funeral Director		218-32-8862 1□M 2XF 8		Yrs.	Months Days	Hours Min.	AUG 11,	v. Year)	Coun	Virginia
			Usual Residence of Decedent	<u> </u>				NOO II,	, 1720	WCDC	VIIGINIA
	how	_	10a. State 10b. County	10c. City	, Town or Lo	cation				1	Od. Inside City Limits
	Be-1 s	cto	Maryland Cecil	Po	rt Dep						1 ☐ Yes 2 🕅 No
	vith th	Director	10e. Street and Number			10f. Zip Code			_	of What Coun	•
	s 23e	erai	1304 Theodore Road  11 Marital Status 12, Was Decedent	Ever in 119	3 13 1	21904	spanic Origin? (Spe	orfy Yes or No		ed Sta	
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "neturel", or Items 23e or 28e-1 show eumatic event, Ite Modical Examiner must be notified at	by Funerai	11. Marital Status  1 Never Married 2 Married  3 Wildowed 4 Divorced  12. Was Decedent Armed Forces?  1 Yes 2 Wilf Yes, Give Year or Dates:			fYes, specify Cuba I⊡Yes 21√2 No	n, Mexican, Puerto I Specify:	Rican, etc.)	E	Black, White, ocify: Whi	etc.
Maryland 21215-0036	2 hou	ted	15. Decedent's Education		16a. Deced	ient's Usual Occupa	ation		16b. Kind of	f Business/Ind	
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2	ygien ygien er th	Completed	8		Hon	nemaker				ler Own	Home
nd	should be filed vand Mental Hygies smarked other tumatic event, III	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name		Maiden Surr	name)	
<u> </u>	nould d Mer marke maric	_C	Okey Tingler  19a. Informant's Name/Relationship (Type, Print)		10h Mailin	un Addross (Straat	Susie Sand Number or Rura		er City or Tox	un State Zin	Code
Z Z	d 2 sl th an th an t7 is r treur		Charles L. Loving/Son			_	ch Road,				
ō,	Heal Heal tem other		20a. Method of Disposition	20b. Pla		sition (Name of natory or other place				on - City or To	
E	Pages ent of nt: If i		1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 14 ☐ Donation 5 ☐ Other (Specify)	⊵a⊥	vary r	lissionar Lemeterv	y June 2007		Rising	Sun.	Maryland
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any injury or other treumatic evente.		21. Signature of Funeral Service Licensee	Трар	22	. Name and Addres		•			Ţ
			23a. Part1. Enter the disease, or complications that cause	the death						rial y la	Approximate
	Physician		shock, or heart failure. List only one cause on each li Immediate Cause (Final	ne. -							Interval Between Onset and Death
п	/Medical		disease or condition resulting in death)  Due to (or as	a qonsequ	ence of):						
	Examiner		Sequentially list conditions, b	0/06		hellete	•				
12	Sit od	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a consequ	ence of):						
7	icate be executed physician and s the burial-transit	Examiner	Cause (Disease of Injury that initiated events resulting in death) Last  Due to (or as	a consequ	ence of):						
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28	ificate g physas the	edicai	a								
O. Box	at the death certific by the attending p tached for use as i	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal	death 3	Ectopic pregnancy Other (specify)			1	Date of delive Month	ry Day Year
٦.	res that t igned by be detar		Part II. Other significant conditions contributing to death b	ut not resu	tting in the ur	nderlying cause give	en in Part I.	23e. Did to	obacco use c	ontribute to th	e cause of death?
g	w requires been sign should be	ed by						101	res 2 No	3 Prob	ably 4 □Unknown
Kecords,	law requires that the as been signed by th 2 should be detache	Completed						24a. Was			osy findings available inpletion of cause of
	The ate h page	Com						perfo	rmed? 2 No	death? 1 🔲 Yes	
VItal	cien: ertific actor,	Be (	25. Was case referred to medical examiner?				26. Place of Death	(Check only o	пе)		A1
0	Phy this ald		1 Yes 2 No Hospital: 1 Inpatie		R/Outpatien 28b. Time of	t 3 DOA Othe	4   Nursing non	ne 5 Resid			Assisted Living
	ding I Ih. After funer	tion	27. Manner of Death    Natural   5   Pending   (Month, Da	y Year)	Injury	Work	res 2 \_No	od. Describe i	iow injury occ	2011-60	
DIVISION	Attendi death. ctor: A vy the fu	fica	3 Surcide 6 Could not be 28e. Place of Inj	ury - At hor	ne, farm, stre	eet, factory, office		28f. Location (S	Street and Nu	mber or Rura	Route Number,
≦	atter s after I Dire	Certification:	4 Homicide determined building, et	c."(Specify)	)			City or Tou	vn, State)		
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the to	edicai (	29a. Certifier (Check only one)  1	f examinati	rledge, death on and/or inv	occurred at the time restigation, in my op	e, date and place, a binion, death occurre	and due to the o	cause(s) and date and plac	manner as st	ated. the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier			29c. License			29d. Date sig	ned (Month, L	Day, Year)
			fucco plan M	D		1008	4823		JUNE	\$ 25	3007
	_		30. Name and address of person who completed cause of c	leath (Item	-	Print)	n Street,	Elkton			,
	Sta Registra		31. Date filed (Month, Day, Year) 2. Registr	ar's Signati		200	·				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND TTEM#1.perPHYS. G869.7/6/07 WS
State of Maryland Department of Pleatin and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Margaret 2. Date of Death 3. Time of Death Lazenby Month Year **Physician** Margaret 2005 M 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Balt More CIT

If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 410 Hospital he Johns HOPKINS 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** 216.32.8501 1 ☐ M 2 ₩ Director Usual Residence of Decedent IOd. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 1 Nes 2 No TIMORE Director MD 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural" ~- " any fijury or other traumatic event." 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify MITE 2 3 ☐ Widowed 4 ☑ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဥ Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) g Address (Street and Nu RNIE, MD. 21061 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition 1 Burial 2 □ Cremation 3 Removal from State CEMETERY 4 ☐ Donation 5 Other (Specify) eral Service me and Address of Facility 21. Signatu Licensee Daugherty Family Funeral Home And Cremation Center, P.A. 2601 Mountain Road - Pasadena, MD, 21122 Approximate Interval Between Onset and Death raπι. Enter the disease are omplications the shock, or heart failure. List only one cause of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a Part1 Enter the disease Immediate Cause (Final disease or condition resulting in death) AGATIC Physician Abdominal ام /Medical Due to (or as a consequence of): Phund Examiner todominal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a consequence of) Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 No 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 ☐ Unknov 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No has le 2 this certificate 26. Place of Death Check onl one 25. Was case referred to medical Medical Certification: To Be examiner in Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 2[] No 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? funeral 27. Manner of Death After Natural 2 Accident 5 ☐ Pending investigation 1 □ Yes 2 □ No М within 24 hours after death

To the Funeral Director:
completely filled in by the f 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3☐ Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4 Baltimore Wolfe St. atturine Pesce 600 N Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 0 6 200

DHMH 17 Rev 1/2001

ORIGINAL

		•	1 - State Registrar	State of M	aryland / I	•	nent of H		and Menta	al Hygien Reg. N	2007	21830
. 3	Physici /Medio	to me a little	1. Decedent's Name (First, Middle, WILL(AN		=701	· L.	EAN	141	/ Mo	te of Death	ay Year	3. Time of Death  12,55 PM
	Examir	ner	4a. Facility Name (If not institution, support of the SHINGTOV)  5. Social Security Number 6	HOVENTYS!	THOSPI	TAL	City, Town, or TAKC Jnder 1 Year	Location of	PARI	K /	c. County of Death	DMENY place (State out or or or or or or or or or or or or or
1	Funeral Director		213-54-8615 Usual Residence of Decedent	1∰M 2□F 54		Yrs. Mo.	nths Days	Hours	Min. Jul	te of Birth onth, Day, Yea y 7, 19		ington, DC
	he Marylar 8a-f ehow offitied at	Director		George's	Ade 1pl	hi				10-0		10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	23a or 2	rai Dir	10e. Street and Number 8906 24th Avenu	ıe		10	of. Zip Code	0783		USA	itizen of What Cou	ntry ?
036	d within 72 hours after death with the Maryland jiene. r then "natural", or tleme 23a or 28a-f ehow the Madical Exempler must be motified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married 3 □ Widowed 4 ゼ Divorced	12. Was Decedent Armed Forces?  1		If Yes	Decedent of Hi , specify Cuba les 2 No	ispanic Origin, Mexican, Specify:	gin? (Specify Ye , Puerto Rican,	es or No- etc.)	14. Race - Ameri Black, White, Specify: Whi	etc.
21215-0036	within 72 ane. then "nai	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)		5+)	(Give kind life. DO N	Usual Occupa of work done of OT use retired	during most ()		16b.	Kind of Business/in	•
Ind 2	be filed tat Hyg d othe event,	Be	17. Father's Name (First, Middle, La		Adi	HIMISC	rative		r's Name (First,	Middle, Maide	Medica n Sumame)	<u> </u>
Maryland		2	William Randolph  19a. Informant's Name/Relationship		198	o. Mailing Ad	dress (Street a		Evelyn r or Aurai Aoute		or Town, State, Zij	Code)
	and 2 Balth a n 27 ion		-Marilyn Kay Hoga	n/Partner				ue, Ad	- 4		nd 20783	
Baltimore,	Pages 1 ment of He ant: If iter uny or oth		20a. Method of Disposition  1 ☐ Burial 2 ☑ Cremation 3  4 ☐ Donation 5 ☐ Other (Spe			ry, cremator	(Name of y or other plac n Crema		June 2	1,	xandria,	own, State Virginia
Ball	permit. Page Department of Important: If eny injury or		21. Signature of Funeral Service Lie	· Ook	4	Fran 500	Univer:	Coll: sity l	ins Fun Blvd, W	., Silv	me Inc. er Sprin	g, MD 20901
TO MAN	Pnysician /Medical Examiner	er	23a. Part.1. Ender the disease, or or or shock, or leart failure. List or immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to infinitediate	a. Due to (or as	ne.	ERO7 of):					DISTAL	Approximate Interval Between Onset and Death
8760,	cate be executed physician and the burial-transit	lical Examiner	cause. Enter Undertying Cause (Disease or injury that indiated events resulting in death) Last	c. Due to (or as	a consequence	of):						
.O. Box 6	death certifi e attending id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death		pic pregnancy er (specify)				23d. Date of deliv Month	ery Day Year
٥.	The law requires that the tee has been signed by the page 2 should be detache	۵	Part II. Other significant condition	contributing to death b	out not resulting i	in the underly	ring cause give	en in Part I.	23	3e. Did tobacco	use contribute to t	./
al Records,		e Completed	75 Was seen referred to mortical						10	a. Was an autopsy performed?	prior to co	opsy findings available impletion of cause of
f Vital	Physician: T this certificat ral director, pi	To Be	25. Was case referred to medical examiner? 1	Hospital: 1 ☐ Inpatie	ent 20 Eli/Oi	utpatient 3[	□ DOA Othe	) F.	of Death (Chec rsing Home 5		6 □Other (Special	<b>(y</b> )
Division of	g fe	ertification:	27. Magner of Death  1 SeNatural 5 Pending 2 Accident investigal 3 Suicide 6 Could no		ry 28b. y Year)	Time of Injury	28c. Injury Work 1 1 "	/at <br Yes 2□N		escribe how in	ury occurred	
Divi	tal or Attendii rs after death. al Director: A ed in by the fu	O	4 Homicide determin	289. Place of In	ury - At home, fa c. <i>(Specify)</i>	arm, street, fa	actory, office		281. Lo Cit	cation (Street a by or Town, Sta	and Number or Rur. te)	al Route Number,
	To the Hospital or within 24 hours after To the Funeral Director completely filled in b	edical	29a. Certifier (Creck only one)  1 Certifying 2 Medical Ex	Physician: To the best aminer: On the basis o and manner st	t examination ar	e, death occi	urred at the tim ation, in my of	ne, date and pinion, deat	d place, and du th occurred at th	e to the cause( ne time, date ar	s) and manner as s nd place, and due t	stated. o the cause(s)
	To the within 2 To the complet	W	29b. Signature and title of certifier				29c. License				ate signed (Month,	
,	8 @		30. Name and address of person wh	o completed cause of c	leath (Item 23a)	(Type, Print)	100	603	19		18,	2007. k, MD 20912
1	Sta Registr	1	DARCIE 7 31. Date filed (Month, Day, Year) JUN 2 1 2		2 76 rar's Signature	ov C	ARR	OLL	TVE.	TAKO	MA PAK	k, MD 20912
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DHMH 17 Rev 1/2001

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			Registrar  1. Decedent's Name (Firs	t, Middle, Last	)			Timodic or L	Jean	2. Date of Dea				3. Time of Death	
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	/Medio Examin		4a. Facility Name (If not in						Location of Death			. County of De	eath	5:05P	_
			Marvel Ha	a11				Easton	1		Ta	albot			
	Funeral		5. Social Security Number		x 7. Age	(In yrs. las		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt	h V. Year	9. E	Birthplac	ce (State or Foreig York	חון
	Director		108-01-46	33	9	5	Yrs.	,		09/19/	191	l1 Ne	w :	lork	
	and w		Usual Residence of Dece 10a. State 10b.	County		10c. City,	Town or Lo	ocation					100	. Inside City Limits	s
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	death	ner	11. Marital Status		12. Was Decedent E Armed Forces?	ver in U.S.	13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (S	pecify Yes or No-	.	14. Race - Ar Black, W			
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3	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23s or 28a-1 show maintry or other traumatic event, the Medical Examination and the rediffied at ODGs.	ted k	15. D	Decedent's Edu	cation		16a. Dece	dent's Usual Occupa kind of work done o DO NOT use retired,	ation	kina	16b. K	(ind of Busine:	ss/Indu	stry	-
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Dallino	ages ant of y or o		1 🔀 Burial 2 □ Cred 14 □ Donation 5 □ 0					matory or other place.	6/20	1/07	ביה 1	la Ch	11.00	sh 777	
	artm. Fortar		21. Signature of Funeral			KING		2. Name and Addres						ch, VA 7y.22042	,
ŏ	Per management		10	-			Na	ational	Funeral						,
			23a. Part1. Enter the dual	re. List only o	ications that caused ne cause on each lin	the death.						***************************************	A	pproximate iterval Between	
	Physician		Immediate Cause (Final disease or condition		CATT	1	Mas	cular	disia	(4)			740	nset and Beath	
	/Medical Examiner		resulting in death)		Due to (or as a	77		-					000	17414	
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Š	h cert endin	M/ul	IF FEMALE: 23b. Was decedent pregr	nant 4	23c. If yes, outcome of			Ectopic pregnancy				23d. Date of	delivery		
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5	g Phy er this eral c	$\vdash$	27. Manner of Death		28a. Date of Injur (Month, Day		8b. Time o			28d. Describe h			Jochy		-
5	ath. r: Aft	atlo	1 ✓ Natural 5 ☐ 2 ☐ Accident	Pending investigation	(Month, Day	rear/	Injury		res 2 □ No						
<u>n</u>	or Atte	Certification:	3 Suicide 6 4 Homicide	Could not be determined	28e. Place of Inju	ry - At hom. (Specify)	e, farm, str	eet, factory, office		28f. Location (S City or Tow	itreet ar m, State	nd Number or e)	Rural F	loute Number,	
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	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Diractor: After this certific completely filled in by the funeral director.	Medical	29a. Certifier 120 (Check only 2 N	Certifying Phy Medical Exami	sician: To the best on ner: On the basis of and manner star	examination	edge, deat n and/or in	h occurred at the tim vestigation, in my op	e, date and place pinion, death occu	, and due to the or rred at the time, o	ause(s date and	) and manner d place, and d	as state ue to th	ed. e cause(s)	
	ro th within ro th	Me	29b. Signature and title of	f certifier)	2P	44 7		29c. License	number		29d. Da	ite signed (Mo	nth, Da	y, Year)	
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	10		30. Name and address of	person who co	ompleted cause of de	eath (Item 2	3а) (Туре,	Print)				ţ	,		
			Dr. Sanche					utchman	s Lane,	Easton	, MD	216	01		
	Sta Registr		31. Date filed (Month, Da)	y, Year) 2 1 20	32. Registra	r's Signatur	0	Parks -							
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			- FOI	tate of Maryland /				Mental Hy	/giene	)	
			1 - State Registrar		Cei	rtificate of I	Death	2. Date of De	Reg. No	2007	3. Time of Death
	Physicia	an	1. Decedent's Name (First, Middle, Last)	rahash Time	1			Month	Day	,	
	/Medic		Katharine Eliz  4a. Facility Name (If not institution, give stre		hicu	m 4b. City, Town, or	r Location of Deat	June	20,	2007 County of Death	8:15 P <sup>M</sup>
<i>F</i>	Examin	er	Vindobona Nursing				k Height			rederic	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last	birthday)	If Under 1 Year	if Under 24 Hrs	<ul><li>8. Date of Bi</li></ul>	rth	9 Birth	place (State or Foreign
	Director		226-09-8032 1 I M	<sup>2</sup> x 97	Yrs.	Months Days	Hours Min.	June 1			intry) yland
	pun *		Usual Residence of Decedent  10a. State 10b. County	10c. City, To	own or Lo	cation					10d. Inside City Limits
	laryla sho ed at	or	,								1 □Yes ¾□No
	the N 28a-1 notifi	Director	Maryland Frederick  10e. Street and Number	Dic	ckers	10f. Zip Code			10a. Cit	izen of What Cou	intry?
	72 hours after death with the Maryland Inatural", or items 23a or 28a-f show dical Examiner must be notified at		9349 Slate Quarry	Road		20842				U.S.A.	•
	death ms 2 r mus	Funeral		Was Decedent Ever in U.S. Armed Forces?	13. \	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (S	Specify Yes or N		14. Race - Amer	
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7 7	withii lene. than he M	duc	Elementary/Secondary (0-12)	College (1-4or 5+)		Secretary	•/		Priv	vate Ind	ividual
ם ם	r Hyg r Hyg other ent, t	Be C	17. Father's Name (First, Middle, Last)	1			18. Mother's Na	me (First, Middle	1		
yland	Ald be Alenta rked tic ev	To B	John Dutrow	Linthicum	n		Leon	a Mae	Davi	is	
Mary	and N s ma	_	19a. Informant's Name/Relationship (Type.	Print) 1	9b. Mailir	ng Address (Street	and Number or R	ural Route Numi	ber, City o	or Town, State, Z	ip Code)
Σ.	and and n 27 in 27 iner tra		Richard W. Hardin			Slate Q	uarry Ro				
o e	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 → Surial 2 → Cremation 3 → Rem	oval from State ceme	etery, crer	sition (Name of matory or other plac		Date	20c. Lo	ocation - City or	Town, State
Saltimor	t. Pa tmen tant: jury		4 □ Donation 5 □ Other (Specify)	Hyat		wn Metho		25/07			Maryland
n D	Deparenti Important Ir		21. Signature of Funeral Service Licensee			Name and Addre	h-Willia	ms_P.A.	, Fur	neral Ho	me
	EAST-SEE	V 1	23a. Part1. Enler the disease, or complicate	ions that caused the death. D		26401 Rid				Marylan	d 20872 Approximate Interval Between
	Obvoicion		shock, or heart failure. List only one of Immediate Cause (Final	cause on each line.		,	J,	, , , , , , , , , , , , , , , , , , , ,	,	ļ	Interval Between Onset and Death
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S.	requires that the een signed by th nould be detache	by P	Part II. Other significant conditions contrib	,	g in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco	use contribute to	the cause of death?
ecords	equire en siç ould b	edt	<u>alzheimer's</u> de	menta,				1 🗆	Yes 2	√No 3 Pro	bably 4 □Unknown
ပ္ပ	ert (f) ou	Completed						24a. Was	s an opsy	24b. Were au	topsy findings available ompletion of cause of
r	T egg	Som							formed?	death?	2 □ No
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5	Physician: The k rr this certificate haveral director, page 2	2	1 ☐ Yes 2 ☐ No Hos  27. Manper of Death	1 Inpatient 2 EH	Outpatier b. Time of	nt 3 DOA Oth	4 W Nursing I			6 □Other (Spec	ify)
SION	ding P. h. After funera	ion:	1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28	Injury	Wor	yaı k? Yes 2 ∐No	28d. Describe	now inju	ry occurred	
S	Atten death ctor: y the	Certification:	3 Suicide 6 Could not be	28e. Place of injury - At home	, farm, str		100 2 110	28f. Location	(Street ar	nd Number or Ru	ral Route Number,
$\leq$	after after Direction b	ertii	4 Homicide	building, etc. (Specify)					own, State		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, to	Sel		an: To the best of my knowled							
	in 24 he Fu	ledical	one)	On the basis of examination and manner stated.	and/or in			urred at the time	e, date an	d place, and due	to the cause(s)
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	)		30. Name and address of person who comp	leted cause of death (Item 23 HM MD 6 /	a) (Type,	Print) Jirth ave	Rain	CINTERE	Ud	21710	2
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last Month Year **Physician** 2300 M Zau June 2007 /Medical acility Name (If not institution, give street and number) Town, or Location of Death 4c. County of Death Examiner town ent Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number Age (In yrs. last birthday)
88 Yrs **Funeral** Days Min. Months 1 ☐ M 2 🖸 F Hours Yrs Director 216-01-8275 02-19-1919 Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 1 ☐ Yes 2 No Chestertown MD Kent Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21620 120 Pine Street IISA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Specify: þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Homemaker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Catherine Brauer Walter Litzau ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Chestertown, MD 21620 120 Pine Street Cathie Blakeney-daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Chestertown, MD 6-22-2007 Chester Cemetery 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Fellow, Helfenbein & 130 Speer Rd Chestertown, MD 21620 21. Signature of Funeral Service Licenses Newnam uch 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Anset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a conse # ence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that fall interests are the control of the contr Due to (or as a consequence of) Examine burial-transit The law requires that the death certificate be executed that initiated events and resulting in death) Last Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4□Pregnant at time of death 9□Unknown 5 Other (specify) 2 No Records, P.O. 9 Unknown Part II. Other sig conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 2 ☐ No 1□ Yes Division or Vital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 R/Outpatient 3 DOA 1 🗌 Yes 1 Inpatient 27. Manny of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred Certification: After Injury 5 Pending investigation 1 Natural 1 🗌 Yes death. 2 🗌 No 2 Accident Director 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a er To the Funeral Director 4 ☐ Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29b. Signature and title of cer 29d. Date signed (Month, Day, Year) 36 05 Y (Item 23a) (Type, Print) peer RD BHaBChester 2)

Registrar

State

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State

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** appr ofkins 5. Social Security Number Baltimore If Under 24 Hrs. Birthplace (State or Foreign Country) If Under 1 Year 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Days Hours Min. Months 1₽M 2□F 218-64-8444 53 7/10/1953 Maryland Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Pages 1 and 2 should be filed within re.vvvv...
ment of Health and Mental Hygiene.
ment: if item 27 is marked other than "natural," or items 23s or 28s-1 show
tant: if item 27 is marked other than "natural," or items 23s or 28s-1 show 1 ☐ Yes 2 ☑ No Director Garrett 0ak1and 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2645 Broadford Road 21550 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 1 Never Married 21 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: δ White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+)
5+ Elementary/Secondary (0-12) Clerk of the Circuit Court County Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Delano Ramsey Martin Betty ျှ Louise DeWitt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 is Deputment of Health ar Important: if item 27 is any injury or other trau Frances L. Martin/ Wife 2645 Broadford Rd., Oakland, MD 21550 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Friend Cemetery 6/27/07 Oakland, Maryland 22. Name and Address of Facility Stewart Funeral Home 21. Signature et Funeral Service Licenses 32 S. Second St., Oakland, MD 21550 Approximate Interval Betwe Onset and De 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Pulmenary Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner 200 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a consequence of) Examiner burial-transit Hospital or Attanding Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical ettending for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown 23a. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۵ the funeral director, page 2 should be 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tyes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 X Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Afte 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. within 24 hours after death To the Funeral Director: completely filled in by the 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide

State Registrar

Medicai

29a. Certifier

(Check only one)

29b. Signatifie and title of certifier

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death (Item 23a) (Type, Print)

Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d, Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rea. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 15 A.M Physician Charles 2007 JUNC 18 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Howard Howard County General Hospital Columbia If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 85 Yrs. 6. Sex 5. Social Security Number **Funeral** Months Days Hours Min. 1 X M 2 □ F 217-16-2684 Nov 26 1921 MD Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 1 ☐ Yes 2X No r 28a-f sh notified Westminster Carroll Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number pe l USA ms 23a 21157 326 Fair Avenue Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married IIWW White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: Completed by 3 Widowed 4 Divorced "natural" 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 27 is marked other than "natu traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mental Hygiene. City of Westminster Department of Works 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Deborah Ireland Fred Reed Muse, Sr ျ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 505 High Acre Drive #114 Westminster, MD 21157 permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any Injury or other trau Lorraine Muse/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 06/2072007 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Hampstead, MD Carroll Cremation, Inc 4 ☐ Donation 5 ☐ Other (Specify) Printer Auneral Home and Chapel, P.A. Signature of Juneral Ser 412 Washington Road Westminster, MD 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final My lo Cocc Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a conseque ce of): Examine burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed nromi that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No 9☐Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 27 No 1 Yes 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1∐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 2 No 2 ER/Outpatient 3 DOA Certification: To 1 TYes Inpatient 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a Date of Injury After (Month, Day Year) Injury 1 ☑ Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death.

To the Funeral Director: A completely filled in by the fu after death 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 1)30641 6 James

W320.4 NA

Charles

Registrar

JUN 2 1 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day,

201-109 Back RIVER NCCR

DHMH 17 Rev 1/2001

State Registrar Wedu ?

DR. GHAZALA OADIR

31. Date filed (Month, Day, Year)

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32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

**ORIGINAL** 

20311 LAPPANS ROAD, BOONSBORO, MARYLAND

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21713

			State of Maryland		artment of H rtificate of I			70	( ) ) **	21000	
			1. Decedent's Name (First, Middle, Last)		imodic or i	Journ	2. Date of Dea	Reg. No.		3. Time of Death	
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	/Medic	aı	4a. Facility Name (If not institution, give street and number)		Morgan	Location of Death	June 1		2007 12:41a <sup>™</sup> : County of Death		
18	Examin	er			Leonard				. Marys		
-			St. Marys Nursing  5. Social Security Number 6. Sex 7. Age (In yrs. la:	st hirthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birtl	1			
ы	Funeral Director		212-14-8610 X□M 2□F 89	Yrs.	Months Days	Hours Min.	(Month, Day	/, Year) <b>/1918</b>	Cour	lace (State or Foreign stry)	
			Usual Residence of Decedent				01/20	/ 1910	mary	land	
	/land ow at		10a. State 10b. County 10c. City,	Town or Lo	cation				1	0d. Inside City Limits	
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	r 28a	Directo	10e. Street end Number	<u> </u>	10f. Zip Code			10g. Citizen of	What Cour	ntry?	
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<u>a</u>	ould be Mental arked o	일	Daniel	Morga		Eliza				scoe	
Maryland	2 shot and N is ma		19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ng Address (Street	and Number or Ru	ral Route Numbe	er, City or Town	, State, Zip	<sup>Code)</sup> 20674	
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١,	12.7		30. Name and address of person who completed cause of death (Item 2	23a) (Type,	Print) Ld. Holl	/	1. 1		10/0	17	
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07-04700	
Timothy Nixon	

imothy Nixon		State of Maryland / Department of Health and Mental Hygiene  1-For State Registrar  Certificate of Death Reg. No. 2007 2183											
Physicia		Registrar  1. Decedent's Name (First, Middle,Last)	. Date of Death		3. Time of Death								
Medical Examin		111100119 27222022	June 19, 20	007	2014 hrs								
		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death Prince Georges Hospital Center  Cheverly		4c. County of Deat Prince Georg									
Function			8. Date of Birth										
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and show	5	MD Prince George's Bowie			1 X Yes 2 No								
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland hand Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shomatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 15102 Jennings Lane	10	g. Citizen of What Co U • S •									
with th		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? ( Spe			rican Indian, Black,								
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical		17. Father's Name (First, Middle, Last)  18. Mother's Name ( Myrtle E.		laiden Surname)									
212 uld be Mental marke event	To Be	John H. Nixon Myrtle E.  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Ru		ber, City or Town, Sta	te, Zip Code)								
AD 2 shou 1 and 1 27 is 1 matic		Karla E. Nixon/Wife 15102 Jennings Lane		MD 20721	1								
e, h l and Health item		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date	20c. Location - City of									
More Pages 1 ent of H nt: If i		1 X Burial 2 Cremation 3 Removal from State MD Crematory or other place MD Veterans Cemetery 6/2	9/07	Cheltenha	ım, MD								
Baltimore, permit. Pages I ar Department of Hee Important: If ite	1	21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. 7474 Landover Rd. B.	. Jenki Landove	ns Funera	Home								
<b>m</b> ₽9 ∏.ii		A.D. I teal			Approximate Interval								
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Division of Vital Records, P.O. Box 68760. To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Pinneral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the b	al C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and	due to the caus	e(s) and manner as s	tated.								
To the within To the comple	edical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at and manner stated.	t the time, date	29d. Date signed (fi									
	Σ	29b. Signature and title of certifier  29c. License number  O.C.M.E.		June 20, 2007	nomi, pay, rear)								
		Falullus 1916		1 30.10 20, 2007									
		30. Name and address of person who completed cause of death (Item 23a)  Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore	e, MD 2120	1									
S	tate	31. Date filed (Month, Day, Year)  32. Registrar's Signature											
Regis	trar	111 2 0 2007 Signal de Carlos											

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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician 4:25 PM June 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Rockville Montgomery Shady Grove Adventist Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 🕱 F 88 Director 2. 1919 ouisiana 302-22-3529 Feb. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notifited at 10c, City, Town or Location 10b. County 10d. Inside City Limits 1X Yes 2 No Funeral Director DC N/A Washington 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 6304 16th St., N.W. 20011 U.S. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. ☐Yes 2☐No fYes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 X No Specify: ğ 3 ☑ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Assistant Professor University 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Daisy George SAmuel J. Young 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6304 16th St., N.W. Washington, D.C. 20011 Cheryl Calloway / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery June 22, 2007 Suitland, MD 22. Name and Address of Facility McGuire Funeral Service, Inc. 21. Signature of Funeral Service Lice 7400 Georgia Ave., N.W. Washington, D.C. 20012 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or s a consequent of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physiclan: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒ No Month Year 4☐Pregnant at time of death 5 Other (specify) been signed by the a should be detached to 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 42 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2/12/No 24a. Was an autopsy performe 2/1/No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes & No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA Certification: To nours after death.

neral Director: After the filled in by the funeral 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 10X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral I to certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and #tle of certifier MD 1)0064 80

State Registrar CENTER DRIVE

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D

32. Registrar's Signature

LIKHMAN

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31. Date filed (Month, Day

			1 - For State Registrar	State of Maryla	nd / Depa			Mental Hy		2007	21841
			1. Decedent's Name (First, Middle, Las	r)				2. Date of Dea	ath		3. Time of Death
	Physic		Matthew John Patk	119				June 18	Day 2	007 Year	7:03P. M
	/Medi Examir		4a. Facility Name (If not institution, give			4b. City, Town, o	or Location of Deat			. County of Deat	
	LAGIIII		4419 Stanford Str			Chevy Cl	nase		М	ontgome	rv
	Funeral	Г	5. Social Security Number 6. Se	x 7. Age (In yrs	last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt			hplace (State or Foreign untry)
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	yland		10a. State 10b. County	10c. C	ity, Town or Lo	ocation					10d. Inside City Limits
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	or 28	ire	10e. Street and Number			10f. Zip Code			10g. Cit	izen of What Co	untry?
	th wi	a	4419 Stanford Stre	eet		20815			Unit	ted Stat	es
	ems erm	ne	11. Marital Status	12. Was Decedent Ever in t Armed Forces?	J.S. 13.	Was Decedent of H	Hispanic Origin? (S an, Mexican, Puerl	pecify Yes or No-		14. Race - Ame Black, White	
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<u>5</u>	within 72 hours after death with the Maryland ene. then "natural", or items 23e or 28e-f show he Medical Examirer must be colified at	lete	15. Decedent's Edu (Specify only highest grad	le completed)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of wor d)	rking	160. K	ind of Business/	industry
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ary.	should be and Mental s marked o	-	19a. Informant's Name/Relationship (T)		19b. Mailir	ng Address (Street	and Number or Ru	ıral Route Numbe	r, City o	or Town, State, Z	Tip Code)
Š	nd 2 alth a 27 is		Nancy A. Patkus /	Wife	4419 Chevy	Stanford Chase,	Street				
re,	of Hei		20a. Method of Disposition	1	Place of Dispo	esition (Name of matory or other pla	!	e 19,		ocation - City or	
Ë	Page int: If	ł	1 ☐ Burial 2 X Cremation 3 ☐ F  ' 4 ☐ Donation 5 ☐ Other (Specify)	Ri.	verdale ematory	e Park	200	-	Rive	erdale,	Maryland
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show many injury or other traumatic event, the Medical Examiner must be notified at ance.		21. Signature of Funeral Service Licens		22	Name and Addre	es of Facility	E CONTRACTOR OF SEC.	D	٨	20910
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	/Medical		resulting in death)	Due to (or as a conse						-	
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	pe sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consec	quence of).						
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×	leath certific attending p	Physician/Med	IF FEMALE:	23c. If yes, outcome of pregn	ancy					23d. Date of deli	ven/
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Re	he lav e has age 2	шc	And And And And And And And And And And					autop perfor	rmed?	prior to death?	completion of cause of
ta	ifcian: Th certificate rector, pag	e C	25. Was case referred to medical				26 Place of Dec	1 ☐ Yes ith (Check only or		1 🗆 Yes	2 <b>∑</b> No
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0	ndin. ath. r: Aft	atio	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day rear)	Injury		Yes 2 □ No				
Division of Vital		ific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, str	eet, factory, office					ral Route Number,
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1	5+1		If he lie	<u>,                                     </u>	- 00.1	D326	510		June	e 19, 20	)() /
-	1		30. Name and address of person who co			· ·	-0 100 0	horry Cl		MD 204	017
	Sta	te	Thomas McNamara, 31. Date fied (Month, Day, Year)	MD 10215 Fer 32. Resistrar's Sign:		Nu., Sull	e 100, 0	nevy cna	ıse,	עונין בעני	317
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene ? For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** 2007 24 Clarence George Paugh, Jr. June 0010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Garrett Garrett County Memorial Hospital 0akland If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) 1 <del>M</del> M 2 □ F Director 236-62-2100 69 30 1937 West Virginia Usual Residence of Decedent permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland beatment of Health and Mental Hygiene. Importent: if item 27 ie marked other then "natural" or pijury or other traumatic event. 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ▼No Tucker Thomas 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 26292 P.O. Box 30 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No If Yes, Give Year or Dates: Korea 14. Race - American Indian, Black, White, etc. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Married 1 ☐ Yes 2X No Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 10 Construction Laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ပ္ Sylvia Shambaugh Clarence G. Paugh, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rachel G. Bonner, Sister P.O. Box 22, Bayard, WV 26707 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cumberland Crematory | 6/25/07 Cumberland, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
David A. Burdock Funeral Home 21 N. Second St., Oakland, MD 21550 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) NULTIPLE Physician PULMONAR /Medical Due to (or as a consequence of): Examiner Securitian, let conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit ding physicien and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Certification: To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 DEctopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown ULMONARY 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No KIGHT 1 ☐ Yes 2 No 25. Was case referred to medical examiner?
1 Yes 2 No 26. Place of Death Check only one Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA this To the Funerei Director: After th completely filled in by the funeral 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation deeth. 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funerel Dire 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a Certifier 29b. Signature and title of certifier 29c. License number Mun 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VA SCHWALM 3 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 2 6 2007 Registrar

**Physician** 

/Medical

**Examiner** 

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Certification: To

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31. Date filed (Month, Day,

allin 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

**Funeral** 

Director

27 Is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

**Physician** 

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the

attending p

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24 hours a

funeral director.

physician

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month June Pinkney 12:30p <sup>M</sup> 2007 James S 18 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Charlotte Hall Veterans Marys 9. Birthplace (State or Foreign Country) Charlotte Hall Home 8. Date of Birth (Month, Day, Year) 09/27/1931 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 2 1 XM 2 □ F Months Days Hours 76 217-28-8746 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 XYes 2 □ No Maryland Prince Georges Brandywine 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 15721 Baden-Naylor Road 20613 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 XYes 2 □ No If Yes, Give Year or Dates: 1952-54 1 □ Never Married 2 □ Married Specify: Black 1 ☐ Yes 2 No Specify 3 Widowed 4 N Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cab Driver 12 Transportation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pinknev Catherine Wilmer McPherson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16905 Horsehead Rd. Brandywine, Maryland20613 Ruby Gross/ Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans 6/29/2007 Cheltenham, Maryland 22. Name and Address of Facility Adams Funeral Home PA 21. Signature of Funeral Service Licensee 191 20605 Aquasco Rd. Aquasco, Maryland 20608 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final RESPIRA disease or condition resulting in death) Due to (or as a consequence of): END STAC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar

29449

20622

William Claudie Reed, Jr.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2007 21844

		1- For State Registrar	Certifi	cate of i	Death		,,	Reg. N	lo.		Trace 3
Physici ledical Exami		Decedent's Name (First, Middle,Last)					Monti		y Year	3	3. Time of Death
ieulcai Exami	ner	William Claudie Reed, JR  4a. Facility Name (if not institution, give street and number)			City Town	or Location of Dea		17, 2007	7 4c. County of I	Dooth	2145 hrs
		23770 Harvey Point Road. Handy Point	Dood		Chesterto		itti		Kent	Jeath	
Funeral			(in yrs. last b	oirthday)	If Under 1 Y	ear If Under 24h	Irs. 8. Date	e of Birth(M	M/DD/YYYY)	9. Birth	place (State or
Director		216-54-9556 1XM 2 F 57	7	Yrs.	Months D	ays Hours M	in.	·	F	oreign Coun	ntry) vz.
		Usual Residence of Decedent						13/1	930		VA
v any		10a. State 10b. County 1	0c. City, Tow	vn or Location	n						Od. Inside City Limits
Maryland 28a-f show d at once	ō	Maryland Kent	Che	sterto	wn						1 Yes 2 XNo
Mary 28a-	Director	10e. Street and Number			10f. Zip Code			10g. C	citizen of What	Countr	y?
th the Maryland 23a or 28a-f she notified at once		23770 Handy Point Road			21620			U	SA		
tems	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces?	ver in U.S.			lispanic Origin? ( an, Mexican, Puei			14. Race - A White, 6		an Indian, Black,
ter death		3 Widowed 4 Divorced If Yes, Give Year	No		Yes 2 X M	lo specify:			Specify: T	п .	
urs af tural	d by	or Dates:  15. Decedent's Education (Specify only highest grade comp	leted) 16a	a. Decedent's	s Usual Occup	ation (Give kind o		e 16b	. Kind of Busin	√hit ness/Ind	
5 72 ho n "na sal Ex	Completed	Elementary/Secondary (0-12) College (1-4 or 5+	-)	during mos	st of working li	fe. DO NOT use r	etired)				
0036 vithin ene. rr tha	m du	7	1	Mechan	ic				Automot	ive	Repair
Filed v Hygi d oth , ihe J		17. Father's Name (First, Middle, Last)				18. Mother's Na			en Surname)		
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be C	William Claudie Reed, SR  19a. informant's Name/Relationship (Type, Print)	- 12	Oh Mailing	Addrona (Ot	Helen eet and Number o			O:: T	O	
b, MD 21215-0036 and 2 should be filed within 72 hours after feath and Mental Hygies liten 27 is marked other than "natural", traumatic event, the Medical Examiner	2	Edith Dolores Reed/ Wife	1								
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland near of Health and Mental Hygiers, the mist. If item 27 is marked offer than "natural", or items 23a or 28a-f she mist. If item 27 is marked offer than "natural", or items 23a or 28a-f she in their traumatic event, the Medical Examiner must be notified at once		20a. Method of Disposition		e of Dispositi	on (Name of	Cheste cemetery,	Date		c. Location - C		
nore		1 XBurial 2 Cremation 3 Removal from State	~I	atory or othe	. ,		/22/0	,			
Baltimore, MD 21215-0036 Departic Pages I and 2 should be filed within 73 Department of Health and Mental Hygiene Important: If tiem 27 is marked other than injury or other traumatic event, the Medical		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	Jouns		metery me and Addre		/23/0		ristia	nsb	urg, VA
De Per M		Kut Selhenbe	$C_{\omega}$	Fe1	lows,	Helfenbe:	in, &	Newna	m Fune	nes ral	tertown MD Home PA
Physician		23a. Part I. Enter the disease, or complications that caused the failure. List only one cause on each line.	e death. Do								Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease a Contact Gunshot	Wound to	o Chest							Death
4		or condition resulting in death)  Due to (or as a conseq	uence of):								
	er	Sequentially list conditions, if any, leading to immediate Due to (or as a conseq	uence of):							-	
	Examiner	C								- 3	
ansit		events resulting in death) Last Due to (or as a conseq d.	uence or):								
Division of Vital Records, P.O. Box 68760, 24 hours after death certificate be executed 24 hours after death. After this certificate has been signed by the attending physician and refunctal Director. After this certificate has been signed by the attending physician and retay filled in by the funeral director, page 2 should be detached for use as the burial - transit	/Medical	UNPENDED XX AMENDED #44a, 28f, pe		0 7/10	/O7 mm						
760, ficate be ex g physician the burial	Mec	IF FEMALE: 23c. If yes, outcome	of pregnance	cy .			_	2	23d. Date of de	livery	
687 Sertific	ian/	23b. Was decedent pregnant in the past 12 months?	mo of dooth			Ectopic preg	nancy		Month	Da	y Year
Box 68 e death certif the attending ed for use as	Physician	1 Yes 2 No 9 Unknown 9 Unknown	ne or death	5 Othe	er (Specify)			- 1			
O. B nat the d od by the etached		Part II. Other significant conditions contributing to death b	out not result	ing in the und	derlying cause	given in Part I.	23e	. Did tobaco	co use contribu	ite to th	e cause of death?
res that signed	d by						_ 1[	Yes 2	<b>✓</b> No 3	Probal	bly 4 Unknown
rds requir	Completed						24a	. Was an autopsy			psy findings available mpletion of cause of
Reco The law cate has	Jub						1.0	performed	? dea	ath?	2 No
tal Recian: The certificate ector, page		25. Was case referred to medical			26.Pla	ce of Death (Chec			INO I	163	2 10
Vits nysicia this ce	o Be	examiner?  1 ✓ Yes 2 No Hospital: 1 Inpatient	2 ER/	Outpatient	3 DQA	Other Nur	sing Home	5 Resi	dence 6	Other: {	Scene
n of ling Pl After funera	T:U	27. Manner of Death  1 Natural 5 Pending FOUND:  28a. Date of Injury FOUND:	28b	. Time of Inju	·	jury at Work?		scribe how i	njury occurred		
ivision or Attend after death. Director: In by the I	atio	Natural 5 Pending FOUND: Accident Investigation Jun 17, 2007		OUND: 28 hrs	1_	Yes 2 ✔ No	Joubjec	31101 30			
Division of Vital Records, state der der Attending Physician: The law requiring the dear death.  al Director: After this certificate has been sided in by the funeral director, page 2 should be	Certification:	3 Suicide 6 Could not be determined (Specify) Single		farm, street,	factory, office	building, etc.	28f. Loc. or T	ation (Stree own, State)	t and Number of <b>Handy Po</b> nt Road; Che	or Rura	Route Number, City
Ospital hours a uneral I ly filled		29a Certifier									
Di To the Hospital within 24 hours a To the Funeral I completely filled	edical	one) 2 ✓ Medical Examiner: On the basis of examiner.									
To To	Me	29b. Signature and title of certifier			29c. Lice	nse number		290	d. Date signed	(Montl	n, Day, Year)
0.0		() 11.			0.0	C.M.E.		Ju	ne 18, 200	7	
20		30. Name and address of person who completed cause of dea	ath (Item 23a	)	<u> </u>						
210		Jack Titus MD. Deputy Chief Medical Exa			Street, Ba	altimore, MD	21201				
	ate	31. Date filed (Month, Day, Year) 9 2007 32. Restrar's	Signature	1	mill.						- 1
Regist	uell.	0011 - 4 E001		0	-						

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			1. Decedent's Name (First,	Middle, La:	st)						-	2. Date of D	eath			3. Tim	e of Death
	Physic /Medi		Darvin Reed	Reck	art							Month June	18.	2007	Year	5:	15 A. <sup>M</sup>
	Examir		4a. Facility Name (If not inst	itution, giv	e street and nu	ım <i>ber)</i>		4b. City.	, Town, or	Location	of Death	-		c. County		1	
			325 Coolidg	e Ave	nue			0a1	kland	l				Garre	tt		
	Funeral		5. Social Security Number	6. S		7. Age (In y	rs. last birthday)	If Unde Months	r 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of B	irth Day Yea	r)	9. Birth	place (Sta	te or Foreign
	Director		216-22-5507		<b>X</b> M 2□ F	79	Yrs.		Dayo	.,,,,,,		Aug.				ylan	d
	and and		Usual Residence of Decede			10c.	City, Town or Lo	cation							Τ.	Ind Inside	City Limits
	Manyl feho	6	MD G	arret	_												es 2 □ No
	288-	ect	10e. Street and Number	illet	L		Dakland	10/ 7%	o Code				100.0	itizen of W	(hat Cau		
	3a or	Funeral Director	325 Coolidge	Δ17.0	nue				550				- ·			•	
	death me 2	era	11. Marital Status	- 1100	12. Was Dec	edent Ever in	1 U.S. 13.			spanic Ori	igin? (Spe	cify Yes or N		ted S		san Indian	
ယ္	after a	표	1 Never Married 2	Married	Armed F	2 No		If Yes, spe	cify Cubai	n, Mexicar	n, Puerto	Rican, etc.)			k, White,		,
03	ours a	by	3 Widowed 4 □ Dive	rced	If Yes, G Year or [	ive	VII	1 ☐ Yes	2 <b>X</b> ☐ No	Specify:				Specify.	Wh	ite	
21215-0036	filed within 72 hours after death with the Maryland Hygiane. ther than "natural", or Iteme 23a or 28a-f show int, the Medical Examinal reval be rediffed at	Completed	15. Dec	edent's Ed	ducation de completed)		16a. Dece	dent's Usu	al Occupa	tion	t of working		16b.	Kind of Bu	siness/In	dustry	
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2	led w lygiar her ti		12				Work	er						rocer		ore	
and	2 should be filed withir and Mental Hygiane. ie marked other than aumatic event, the Mi	Be	17. Father's Name (First, Mi									(First, Middl	e, Maide	n Sumami	э)		
3	should nd Men marke umatic	2	William Recl								el Up						
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Ba	permit. Pages Depertment of Important: If it any injury or c		to and a	1	51 512	-B	24	Name ar Davi	d A.	Burd	ock .	Funera	1 Hc	me, I	P.A.		
			23a. Part1. Enter the disease	e. or com	plications that	caused the de	ath Do not ent	ZIN	. Sec	cond	St.,	0akla	nd,	MD 21	L <u>550</u>	Approxim	nate
	Dharatatan		shock, or heart failure. Immediate Cause (Final	List only	one cause on									1		Interval f Onset ar	Between
	Physician /Medical		disease or condition resulting in death)	-	a ART	(or as a cons	SCC37	2011	' (	Cono	w otr	14 Vas	KUL	av		MM	This
	Examiner				D09 (0	(or as a cons	equence on:					d	sa	عدا			
		je.	Sequentially list conditions, if any, leading to immediate	J	b. Due to	(or as a cons	equence of):										
	cuted	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	1	C												
oʻ	an ar rial-t		resulting in death) Last	-	Due to	(or as a cons	equence of);										
68760,	cate be executed physician and the burial-transit	dical		•	d												
Ψ	ing p	Med	IF FEMALE:														
Box	death certifi e attending p id for use as	an/	23b. Was decedent pregnar in the past 12 months?	t	23c. If yes, ou 1☐Live t	tcome of prec pirth 2 ☐ Fo		Ectopic pr	regnancy					23d. Date		•	
	0 0	Physician/Me	1 Yes 2 No		4⊡ Pregr 9⊡ Unkn	nant at time o own	f death 5□	Other (sp	ecify)					Mon	tn	Day	Year
P.0	requires that the		Part II. Other significant con	ditions of	ontobuting to d	eath but not r	oculting in the u	ado eb sio e a		a ia David		200 Did	10h				
Records,	signe d be	d b	Takin only significant con		or tributing to a	eath but not i	esalting in the ur	idenying c	ause give	n in Part I.			Yes 2	use contri			or death?
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a		O										1□ Yes	2		eath?	2□ No	
⋚		Be c	25. Was case referred to me examiner?	1/-	Hospital:				Other	~		Check only					
ō	Phy r this ral di	6	1 Tes 2 No		1		ER/Outpatien 28b. Time of		<u> </u>	4 🗆 1401		8d. Describe		6 Othe		1)	
o	iding Ph th. : After thi funeral	후	1. Natural 5 Pe	nding estigation	(Mon	th, Day Year)	Injury	м	8c. Injury Work: 1 □ Y	?` es 2 □ N		ou. Describe	now mje	ary occurre	· ·		
Division of Vital	I or Attending effer death. Director: After I in by the fune	ertification;	3 ☐ Suicide 6 ☐ C	uld not be termined	28e. Place	of Injury - At	home, farm, stre					8f. Location	Street a	nd Numbe	r or Rura	l Route M	ım ber
á	2 4 5 6	Cert	4 🗍 Hornicide Ge	Commica	buildi	ng, etc. <i>(Spe</i>	cify)					City or To	wn, Stat	е)		, , , , , , , , , , , , , , , , , , , ,	
	pspit hours uners y fille		29a. Certifier 1 ☐ Cert	ifying Phy	ysician: To the	best of my k	nowledge, death	occurred	at the time	e, date and	d place, a	nd due to the	cause(s	s) and man	ner as st	ated.	
	To the Hospital or Atten within 24 hours effer deat To the Funeral Director; completely filled in by the	edical	(Check only 2 Med one)	ICBI EXOM	iner: On the b	asis of exami ner stated.	nation and/or inv	estigation,	, in my opi	nion, deat	h occurre	d at the time,	date an	id place, ar	nd due to	the cause	)(s)
	To To To To To To To To To To To To To T	Σ	29b. Signature and title of ce	rtifier	/		200	290	. License	number		,	29d. Da	te signed	(Month,	Day, Year,	
			1 Den	S	nel	LX			HZ	61	20	1	(	à L	71	07	-
		U	177	son who c	completed caus	e of death (t	em 23a) (Type, I	Print)	100	4	M.	v.0	. 1.	.1	0 1	10	מלטונ
		1	31. Date filed (Month, Day, Y	2000)	WILL	evt	0 69	, WG	111	1516	10	N. O	a x	tane	ex m	MUZ	1346
	Sta Registr				2007	egistrar's Sig	A A	200-00	0								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** WI JUNE 200 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Howard Columber If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. See 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 M 2 □ F Days Hours 87 SEPT. 26, 1919 Clarenton, S.C. 248-20-528 Yrs Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐Yes 2 ☐ No RALTIMORE Funeral Director MO 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 4.S.A 212187 1603 MONTPELIER STREET 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Specify: RLACIL Specify <u>م</u> 3 ☐ Widowed 4 ☐ Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ASONER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle Last) Be MARTHA WILDER ဂ္ 19a. Informant's Name/Relationship (Type(Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BACTO, MS. 1603 MONTRELIER ST. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State WoodLAWNE CEM. BALTIMORE JUNE 25 2007 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility GARILL. ROILINS FUNDER HOME 21. Signature of Funeral Service Licens FRED. M.D. Her 23a, Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 30 minutes **Physician** /Medical Due to (or as a consequence of): **Examiner** Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence on Examine or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death
9☐Unknown 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown Be Completed Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed this certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 VNo 1 ☐ Inpatient 2 ☑ ÉR/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. after death Director: the filled in by 4 □ H 29a. Certi (Che

To the Hospital or within 24 hours a To the Funeral C

uicide omicide	6 Could not be determined	28e. Place of injury - At building, etc. (Spe	home, farm, street, f cify)	actory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)						
fier ck only				curred at the time, date and place, gation, in my opinion, death occu				use(s)			
ature and	title of certifier	li Khayn	M.D.	29c. License number D433	23	29d. Date signed (Mo	nth, Day, Yei	ar) 200			

State Registrar 29b. Sign

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Oeath 1. Decedent's Name (First, Middle, Last) Month Day 1: 25 P.M June 22, 2007 **Physician** ROBINSON Dane Eugene /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Frederick Frederick 6566 Whetstone Drive 9. Birthplace (State or Foreign | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Nonths | Days | Hours | Min. | April 25,1950 7. Age (In yrs. last birthday) 5. Social Security Number Maryland **Funeral** 1X M 2□ F 57 Yrs. 082-42-9991 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location filed within 72 hours after death with the Maryland Hygiene. 10a. State 10b. County 1 ☐ Yes 2 No Frederick Frederick Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21703 6566 Whetstone Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 Styes 2 □ No 196 If Yes, Give Year or Dates: 19 11 Marital Status 1969 Specify: black 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify: Baltimore, Maryland 21215-0036 1993 Ď 3 ☐ Widowed 4 ☐ Divorced 16h Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) 4 Elementary/Secondary (0-12) utility management 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Brooks Helen Robinson Robert of Health and Menta Item 27 is merked rother treumstic e is marked 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Depertment of Health and Important: If Item 27 is m eny injury or other treum page. 6566 Whetstone Drive, Frederick, Maryland 21703 Rosalyn Robinson - wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition June 27, 2007 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Hagerstown, Maryland Rose Hill Cemetery 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CANCER PANCREATIC Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physicien end s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical use as the the attending 23d. Date of delivery 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death IF FEMALE 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month 4☐ Pregnant at time of death ŏ in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown detached 23e. Did tobacco use contribute to the cause of death? signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 No 2 No 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 ☐ Nursing Home 5 ☐ Kesidence 6 ☐ Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No ٩ this 28d. Describe how injury occurred s efter death.
I Director: After this id in by the funeral d 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death Medical Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be determined 3 Suicide 4 - Homicide To the Hospital or within 24 hours off To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 021936 Dme lon 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A. DONGLOUN MD 65C THAMAS JOHNSON DR FREDERICK MD 21702 A. DONELSON MD 32. segistrar's Signature 31. Date filed (Month, Day, Year) State JUN 2 5 2007 Registrar

DHMH 17 Rev 1/2001

Division or Vital Records, P.O. Box 68760, within 24 hours after dea To the Funeral Director completely filled in by the To the Hospital

415 East Wilson Blvd., Hagerstown, Maryland 21740 Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ひりつスろう aurino 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HAGEKSTOWN KELLI STRAUSS PENNSY WANIA AVE 21742 MD Year) 25 State 2007 Registrar DHMH 17 Rev 1/2001 **ORIGINAL** 

		ŀ	1 _ State	State of Maryland		artment of H					
			Registrar  1. Decedent's Name (First, Middle, Last)			tinoate or i	Jeani	2. Date of Death	g. No:	111	3Time of Death
	Physici	an						Month	Day	Year	
	/Medic		Cecelia Sayle  4a. Facility Name (If not institution, give s.			4b. City, Town, or	Location of Deat		19, 20	tv of Death	4:10pm <sup>™</sup>
	Examin	er								1	-
			Manorcare of Poto  5. Social Security Number 6. Sex		ast hirthday)	Potoma If Under 1 Year	If Under 24 Hrs	8. Date of Birth	Monts	gomery	place (State or Foreign
Н	Funeral Director		1 🗆	M 21XF 84	Yrs.	Months Days	Hours Min.		Year)	Сои	ntry)
			101-16-7741 Usual Residence of Decedent	04				100/13/1	922	VILE	ginia
	and is		10a. State 10b. County	10c. City	, Town or Lo	cation					10d. Inside City Limits
	Many f sh	io	MD Montgomer	To Pos	tomac						1 ☐ Yes 🏋 No
	the 28a	Director	10e. Street and Number	y 10	Lomac	10f. Zip Code		10	g. Citizen o	f What Cou	ntry?
	3a or		10714 Potomac Ter	nnis Lane		20854	'L		U.S.	Α.	
	TIS 2	by Funeral		2. Was Decedent Ever in U.	S. 13.	Was Decedent of H f Yes, specify Cuba		Specify Yes or No-	14. Ra	ace - Ameri	
·0	rita	교	1∑ Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No	i			to Rican, etc.)	BI	ack, White,	etc.
ဗ္ဗ	urs a	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2½ ∏ No	Specify:		Spec	ify: Bla	ick
Õ	2 ho	Completed	15. Decedent's Educ	eation	16a. Dece	dent's Usual Occup	ation		6b. Kind of		
풊	hin 7	ple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done on DO NOT use retired	during most or wo	rking			
7	d wit	Our	12		Wai	tress			Food S	Servic	e
Þ	othe othe	Bec	17. Father's Name (First, Middle, Last)			:	18. Mother's Na	me (First, Middle, M	faiden Suma	am <i>e)</i>	
Maryland 21215-0036	Abnta Abnta rked tic e	ToE	Cecil Sayles				unkı	nown			
ary	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic evant, the Madical Examinator musitic and once.		19a. Informant's Name/Relationship (Typ	oe, Print)	19b. Mailir	ng Address (Street	and Number or Ri	ural Route Number,	City or Tow	n, State, Zip	Code)
Σ	alth alth 27 I		Ricardo Sayles -	- Son	18011	Sutters	Mill Way	y Dumfri	es, Vi	irgini	a 22026
Baltimore,	itam itam		20a. Method of Disposition		ace of Dispo	sition (Name of natory or other place	e) I		0c. Location	- City or To	own, State
Ë	Page ient c nt: If ry or		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re  `4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		rematory	06/2	9/2007 <sub>D</sub>	ale Ci	Lty. V	irginia 221
Ħ	orta		21. Signatur Funda Service License				ss of Facility Mo	ountcast1			
m	Depa Impo any ir		Valet Mile	W.	41	43 Dale I	Blvd,Dale	e City, V	irgini	la 221	93-2224
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final	cations that caused the death e cause on each line.	. Do not ent	er the mode of dyin	g, such as cardia	c or respiratory arre	st,		Approximate Interval Between Onset and Death
Н	Pnysician /Medical		disease or condition resulting in death)	_		CINOMA T	O LUNG				3 Months
	Examiner			Due to (or as a consequ							
		-	Sequentially list conditions, b.	. ABDOMINA Due to (or as a consequ		INOMA					3/m.
J	ted nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	(							
3	xecu and al-tra	хаг	that initiated events c. resulting in death) Last	. Due to (or as a consequ	ience of):						
760,	icate be executed physician and s the burial-transit	alE									
687	The law requires that the death certificate be executed ate has been signed by the attending physician and age 2 should be detached for use as the burial-transit	dical		,							
	that the death certific ed by the attending p detached for use as	/Me	IF FEMALE:	3c. If yes, outcome of pregna	ncv				234 [	ate of deliv	97/
. Box	atter for u	ciar	in the past 12 months?	1 Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)				Month	Day Year
o.	the d	ysic	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown	,447						
Division of Vital Records, P.O	that the ed by deta	by Physician/M	Part II. Dther significant conditions con-	tributing to death but not resu	ılting in the u	nderlying cause giv	en in Part I.	23e. Did tob	acco use co	ntribute to t	he cause of death?
ď	signed of the details	d b	Diabetes Mell	itua				1 ☐ Ye	s 2√2 No	3 ☐ Prol	babiy 4 ⊡Unknown
Ö	w requir been s should	Completed	Comment Ambo	my Diagona				24a. Was ar	245	Mara aut	angu findinga ayaylabla
š	has ye 2	d L	Coronary Arte	ly Disease				autopsy perform	/	prior to co death?	opsy findings available ompletion of cause of
<u> </u>		S							No	1 Yes	2[]No
<u> </u>	Attending Physician: Thir death. actor: After this certificate by the funeral director, pag	Be	25. Was case referred to medical examiner?	ospital:		Oth		ath (Check only one			
of	Phys this al dir	7	Tes ZUNO	1   Inpatient 2	ER/Outpatier	IL 3 DOA	4A Nursing i	Home 5 Reside			fy)
E C	ding h. h. After funer	on	27. Manner of Death 1 → Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wor	k?	28d. Describe ho	w injury occi	urred	
S	tend leath tor:	cat	2 Accident investigation 3 Suicide 6 Could not be	00 - Di			Yes 2 □No	296 Lacation /Cts	mak and blum	nhor or Dea	al Davida Mumbar
<u>≥</u>	after of Dirac	Certification:	4  Homicide determined	28e. Place of Injury - At ho building, etc. (Specify		eet, ractory, office		28f. Location (Str City or Town		nber or Hur	al Houte Number,
	ospital hours a unaral (		00. 0. 4% - 457 0. 4% 1. 10.								
	I 4 II 0	edical		ician: To the best of my know lef: On the basis of examinat and manner stated.							
	To the within 2 To tha complet	Med	29b. Signature and title of certifier	^		29c. Licens	e number	29	d. Date sign	ned (Month,	Day, Year)
	F ≥ F 8		* Atophas	I not		D 313	319		26 Jun		
	Λ		on Normand	mulated as a second file	220\ / T =	Drint\					
			30. Name and address of person who con	· ·		-	Rothord	9 MA 200	81/-20	105	
		ta	Loreto S. Albiol	32 Registrar's Signal		SIN AVE.	Derliesda	a, FIG. 200	314-25	, U J	
	Sta Registr		11 0 6 200	1	Ann	and I					

		1 - For State Registrar	Oldio o	- warylan	-	rtificate			Mental Hy	Reg. No.	Z IIII .	7 2185
Physic	ian	1. Decedent's Name (First, Middle, Las	,						2. Date of D Month	Day		3. Time of Death 9:32 p
/Med		Boon Jo Son,  4a. Facility Name (If not institution, give		nher)		4h City T	Town or f	Location of Dea	June	18	County of Dea	
Exam	iner	21920 Greenbro		nber)		TD. City, 1	owii, oi i	Boyds	2011	40.	Montgo	
Funera	4	5. Social Security Number 6. S		7. Age (In yrs. I	ast birthday)	If Under		If Under 24 Hr	s. 8. Date of B	irth ay, Year)	9. Bi	rthplace (State or Fore
Directo		219-04-0393	□M 2 <b>K</b> F	92	Yrs.	Months	Days	Hours Mir	March 2			Korea
pur χ		Usual Residence of Decedent  10a. State 10b. County		10c City	, Town or Lo	cation						10d. Inside City Limi
larylarylarylarylarylarylarylarylarylary	ō			,	,		German	a t arm				1 □ Yes 2 🛣
the N 28a-	Director	Maryland Montgome  10e. Street and Number	Гу	·		10f. Zip (		ILOWII		10g. Cit	izen of What C	ountry?
3a or		21000 Father Hurley	Blvd #	<b>:3</b> 22				20874			U.S.	Α.
deatl	Funeral	11. Marital Status		edent Ever in U.:	S. 13.	Was Decede			Specify Yes or Nerto Rican, etc.)	lo-	14. Race - Am Black, Wh	
be filed within 72 hours after death with the Maryland ttal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes If Yes, Giv Year or D	2 ☑ No /e		1 □ Yes 2		Specify:	710 1 110 411 7 0 10 1 7		Specify:	Asian
72 ho natur sical I	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)		16a. Dece	dent's Usual	l Occupa	tion	orkina	16b. K	ind of Business	s/Industry
within iene. than "	nple.	Elementary/Secondary (0-12)	College (1	-4or 5+)	life.			uring most of w	onung			
filed w Hygier ther th		12 17. Father's Name (First, Middle, Last)				Publi	ic Se		ame (First, Middl		Governme	nt
should be filed wind Mental Hygie smarked other tumatic event, the	Be	Yong Soo Song							soo Ki		Sumame)	
2 should and Men is marke	2	19a, Informant's Name/Relationship (	Type. Print)	-	19b. Mailir	na Address	(Street a		Rural Route Num		or Town, State.	Zip Code)
nd 2 suith ar alth ar 27 is r trau		Kyung Lee - Daughte	**		I				mantown,			
pes 1 and 2 of Health if item 27 is	6	20a. Method of Disposition			lace of Dispo emetery, crei	sition (Nam	e of ther place	9)	Date	20c. Lo	ocation - City o	r Town, State
Pages nent of I int: If ite	4	1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Domation 5 ☐ Other (Specifi		State	beck Me			1	22/2007	01ne	y, Maryl	and
permit. Pages 1 and 2 should Department of Health and Mer Important: If item 27 is marke any injury or other traumatic		21. Signature of Funeral Service Licensee  22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver									nrino. M	arvland 20904
6 8		23a. Part1. Enter the disease, or com shock, or heart failure. List only	olications that o	aused the death							P126;	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition		ver Cance	r							Onset and Death
/Medica		resulting in death)	a,	(or as a consequ			10					
Examine		Sequentially list conditions, if any, leading to immediate	D.	cites								
pa. tis	ine	if any, leading to immediate cause. Enter Underlying cause (Disease or Injury that initiated events		or as a consequ								
xecut and	Examiner	that initiated events resulting in death) Last	Ų	pertensio (oras a consequ								
ficate be executed physician and the burial-transit	Sal		d									
tificate g phy as the	ledical									1		
The law requires that the death certificate has been signed by the attending phoage 2 should be detached for use as the	Physician/M	IF FEMALE: 23b. Was decedent pregnant		come pf pregna birth 2 🗆 Fetal		∃Ectopic pre	egnancy			-	23d. Date of d	
e dea he att	sicia	in the past 12 months? 1 □ Yes 2 🖺 No		ant at time of de		Other (spe		_			Month	Day Year
that the denethed by the a	Phy	9 Unknown  Part II. Other significant conditions of	ontributing to d	noth but not rocu	ulting in the u	ndorlying oo	uso alvo	n in Poet I	230 Did	Ltohacco	uso contributo	to the cause of death?
ires the signer	by	Part II. Other significant conditions of	ontributing to de	eam but not rest	alling in the u	ndenying ca	ause give	nın Panı.				Probably 4 \(\subseteq Unknown)
w require been si should b	eted											
The law cate has l	Completed								24a. Wa - aut	is an opsy formed?	24b. Were a prior to death?	autopsy findings availal completion of cause o
	ပိ	25. Was case referred to medical						Of Place of D	1□ Yes	2 🗓 No		
Physician: this certifican and director, I	m		Hospital:	Innatient 2 🗆	ER/Outpatier	nt 3 🗆 DO	Otho	p.	eath (Check only		6 ₹10thor (Sa	ecify)Son's Resi
	n: To	27. Manner of Death	28a. Date		28b. Time o		8c. Injury Work		28d. Describe			ecny) o o i o o o o
Attending I r death. ector: After by the funer	atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation		iii, Day Teai)	Injury	М		: ′es 2 □ No				
- 9	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place buildi	of injury - At hoing, etc. (Specif)	ome, farm, str //	eet, factory,	, office			(Street ar own, State		Rural Route Number,
To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical C	29a. Certifier (Check only one) Certifying Ph	niner: On the b	e best of my know asis of examination	wledge, deat tion and/or in	h occurred a vestigation,	at the tim , in my op	e, date and pla pinion, death oc	ice, and due to the	e cause(s e, date an	) and manner a d place, and di	as stated. ue to the cause(s)
<b>Го th</b> e vithin Го the	Me	29b. Signature and title of certifier	/	/		29c.	License	number		29d. Da	te signed (Mor	nth, Day, Year)
1		N \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	_/	5.	1		7	13/	7 /	N	in o	(G 7 ?
6		30. Name and address of person who	completed caus	se of death (Item	23a) (Type,	Print)		1.	7	0	vije 1	7/2001
		892154ady	Frove.	ct, 1	Kuil	HYSE	Perx	Ma	1,208	577,	Bo	KILI
4 S	tate	31. Date filed (Month, Day, Year)	32. 5	egistrar's Signa	ture		2.	,				

DHMH 17 Rev 1/2001

			For State Registrar	State of Mar		ertificate of		,	Reg. No		0101
**	Physici	an	1. Decedent's Name (First, Middle, Last	t)				2. Date of De Month		y Year	3. Time of Death
	/Medic		William		Singh			June		<sup>y</sup> 2007 <sup>Year</sup>	9:10p м
	Examin	er	4a. Facility Name (If not institution, give				or Location of Deat		4c	. County of Death Montgoi	
- 2	Funeval	9	1627 Ingram Te: 5. Social Security Number 6. Se		In yrs. last birthda		er Spri		th	wid.	-
	Funeral Director		216-45-2070	XM 2□F	81 Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da 5 / 05 /	192 192	26   Cou	place (State or Foreign intry) ndia
	land Dw It		Usual Residence of Decedent  10a. State 10b. County	1	0c. City, Town or			<u> </u>			10d. Inside City Limits
	e Mary 3a-f sho tiffied a	ctor	MD Montgom	nery	Silve	r Spring	ſ				1 ☐ Yes 2 🙀 No
	be filed within 72 hours after death with the Maryland ntal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed by Funeral Director	10e. Street and Number 1627 Ingram Ter	race		10f. Zip Code 20	906		-	tizen of What Cou India	intry?
	r dea tems	uner	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S.	. Was Decedent of I	Hispanic Origin? (S ban, Mexican, Puer	Specify Yes or No to Rican, etc.)	)-	14. Race - Ameri Black, White	
036	ours afte rai", or it Ex. min	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 ☐ Yes 2 🙀 No	Specify:			Specify: A	sian
15-0	in 72 ho n "natu Aedicai	pletec	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	16a. Dec (Giv life	edent's Usual Occu re kind of work done DO NOT use retire	pation during most of wo ed)	rking	16b. K	ind of Business/li	ndustry
212	d with giene er thau	mo:	Elementary/Secondary (0-12)	5 +		Physici				Medica	1
land	ld be file lental Hy ked othe ic event	To Be (	17. Father's Name ( <i>First, Middle, Last</i> )  Ajit Singh					me ( <i>First, Middle</i> ndra A.			
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	_	19a. Informant's Name/Relationship (7 Snehlata Singh/	ype. Print) Daughter		iling Address <i>(Street</i> 27 Ingra					ip Code) J,Md 20906
	item		20a. Method of Disposition		20b. Place of Dis	position (Name of rematory or other pla	ace)	Date	20c. L	ocation - City or T	own, State
E G	Page ant: if		1 <b>X</b> Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other ( <i>Specify</i>			f Heave	n 6/2	1/2007	Si	lver S	pring,Md
Baltimore,	permit. Departr Imports any inj		21. Signature o Funeral Service Licens	medica		PHILIPAdd 9241 Col					CE, P.A. ng, Md20910
Ŗ,	- 21		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	olications that caused the						_ DPIII	Approximate Interval Between
9	Physician		Immediate Cause (Final disease or condition			Failure					Onset and Death
Ž.	/Medical Examiner		resulting in death)		onsequence of):						
16	- Administra	je.	Sequentially list conditions,	b. Pulmor		berculos	sis				
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events								
Ö,	rtificate be executed ig physician and as the burial-transit		resulting in death) Last	Due to (or as a c	consequence of):						
68760,	ate be	edical		d							
			IF FEMALE:	23c. If yes, outcome pf	pregnancy					23d. Date of deliv	von.
Вох	The law requires that the death cer ate has been signed by the attendir bage 2 should be detached for use	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 2 l 4□Pregnant at tin	Fetal death	□Ectopic pregnand □ Other (specify) _	у			Month Month	Day Year
Ö.	at the c by the tached	hysi	9□Unknown	9□Unknown							
S, P	es tha igned be de	by P	Part II. Other significant conditions of		-	underlying cause gi	ven in Part I.				the cause of death?
ord	w requires t s been signe s should be	ted	Congestive hea		ce			10	Yes 2	X No 3 □ Pro	obably 4 ☐Unknown
3ec	ne iaw has b ye 2 sl	Completed by	Aortic stenosi	S				24a. Was		24b. Were aut prior to c death?	topsy findings available ompletion of cause of
a	ician: The certificate ha		25. Was case referred to medical				00.51 (5	1□ Yes	2 🔀 No		2□No
S	Physician: r this certifica ral director, p	o Be	examiner?	Hospital:	2 ER/Outpati	ent 3 DOA Ot	hor:	ath <i>(Check only o</i>		6 □Other (Spec	i6d
0	g Phy er this eral d	n: To	27. Manner of Death	28a. Date of Injury	28b. Time	of 28c. Inju		28d. Describe			ny)
ion	Attending r death. ector: After by the fune	atio	1 Natural 5 Pending 2 Accident investigation		'ear) Injury		Yes 2 No				
Division or Vital Records,	after des after des I Directo d in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury building, etc. (	- At home, farm, (Specify)	street, factory, office		28f. Location ( City or To			ral Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical C		ysiclan: To the best of ininer: On the basis of each and manner state	xamination and/or						
	To the within 2 To the comple	Me	29b. Signature and title of certifier	1			se number			ate signed (Month	
	-2		find M	(Junel	Pmn						2007
	~		30. Name and address of person who of Linda Burrell	MD 2730	Univer	sity Blv	d. #400	Wheat	on,	Md 2090	2
	Sta Registi		31. Date filed (Month, Day, Year) JUN 2 1 2	32. Relistrar's	S Signature	boute					
DH	IMH 17 Rev 1/2	001									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 23a or 28a-f show any Injury or other tran "natural", or items 23a or 28a-f show any Injury or other tranmatic event, the Medical Examiner must be notified at	
	Physicia /Medica Examina	
Division or Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed by the Wilhing 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the bursal-transit	

	For State Registrar		(	Certificate of	Death		g. No. 200	17 2105					
an	1. Decedent's Name (First, Middle, Ann Patricia S	,				2. Date of Death Month	Day Ye	ar 2 • 45 P					
cal				4h City Town o	Location of Death	June	16 200 4c. County of D						
ner	4a. Facility Name (If not institution, Golden Living	-		Frederic			Frede						
4			(In yrs. last birth		If Under 24 Hrs.	8. Date of Birth	9	Birthplace (State or Fore					
	577-46-5649	1□M 21XF	72 Y	rs. Months Days	Hours Min.	(Month, Day, June 26	rear)	Country) ashington, I					
	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limi					
to	MD Frede:	rick	Frede	rick				1 □ Yes 2 🔼 N					
)irec	10e. Street and Number			10f. Zip Code		10	g. Citizen of What	Country?					
ra [	6501 Spring Wat	er Court		2170			USA						
by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Marrie 3 ☒ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? ad 1 □ Yes 2 ☑ N If Yes, Give Year or Dates:		13. Was Decedent of H If Yes, specify Cube 1 ☐ Yes 2 No	ispanic Origin? (Spo an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		merican Indian, /hite, etc. White					
eted	15. Decedent' (Specify only highest		16a. D	Decedent's Usual Occup	nt's Usual Occupation of of work done during most of working NOT use retired)			ess/Industry					
Completed	Elementary/Secondary (0-12)	College (1-4or 5-	+)	life. DO NOT use retired Homemaker	1)		Ноперы	ife					
	17. Father's Name (First, Middle, L	act)		nomemaker	er Housewife  18. Mother's Name (First, Middle, Maiden Surname)								
Be	Andrew Paul Bus				Adaline		a.son ourname)						
욘	19a. Informant's Name/Relationsh		19b. I	Mailing Address (Street			City or Town, Stat	te, Zip Code)					
	Cynthia A. Zimm			East "H"				716					
	20a. Method of Disposition	0 [ ] Dame:	20b. Place of E	Disposition (Name of crematory or other place	ce)	Date 2	0c. Location - City	or Town, State					
	1 ☐ Burial 2 🖾 Cremation 4 ☐ Deflation 5 ☐ Other (Sp		1	town Cremat	i i	7/07 Н	agerstow	m, MD					
	21. Sign August Virginic Censel 1 22. Name and Address of Facility John T. Williams Funeral Home 100 Petersville Road, Brunswick, MD												
	Barbara A. W			100 Peter	sville Ro	ad, Brun	swick, MI	D 21716					
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and Death												
	Immediate Cause (Final disease or condition resulting in death)	_a.	1	Jung	a	neer	/	Oliset and Death					
	resulting in death)	Due to (or as a	a consequence of	):									
<u>.</u>	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	a consequence of	1.									
Examiner	Cause (Disease or injury	5 de 10 (01 da 6	2 consequence of	,.									
xar	that initiated events resulting in death) Last	c Due to (or as a	a consequence of	):		<del></del> -							
edical E		d											
		I.				50.50	11 3 3						
ysician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome p 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death	3 □Ectopic pregnanc 5 □ Other (specify) _	′		23d. Date of Month	delivery Day Year					
y Phy	Part II. Other significant conditio	ns contributing to death bu	it not resulting in t	the underlying cause giv	en in Part I.	23e. Did toba	acco use contribut	te to the cause of death?					
ed by						1 □ Yes	s 2 No 3	Probably 4 Onkno					
ompleted						24a. Was an		e autopsy findings availa					
шо					<del>-</del>	autopsy perform	ed? deat						
Se C	25. Was case referred to medical examiner?				26. Place of Deat	h (Check only one							
5 8	1 Yes 2 No	Hospital: 1 ☐ Inpatie	nt 2 ☐ ER/Outp		4 Mursing Ho	me 5 Resider	nce 6 🗆 Other (5	Specify)					
ertification:	27. Manner of Death  1 Natural 5 Pending investig.	ation	Year) Inj	ury Wor M 1□	yat k? Yes 2 □ No	28d. Describe how	w injury occurred						
O	3 Suicide 6 Could n 4 Homicide determi	ned building, etc	c."(Specify)	n, street, factory, office		City or Town,	State)	r Rural Route Number,					
edical		Physician: To the best of Examiner: On the basis of and manner sta	examination and										
Me	29b. Signature and title of contilier	1	$\sim$	29c. Licens	e number 5839	29	d. Date signed (M	onth, Day, Year)					
	30. Name an inddress of per	vio comple 4 use of de	eath (Item 23a) (T	ype, Print)  1 Toll H	ouse	AUR,	Frede	evel. M					
ate	31. Date filed (Month, Day, Year)	32. Fegistra	ar's Signature	Sports	V			2/7/					
410		u / 21117   177// A	44 A A	# "# TOTAL T									

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2007 Year Day **Physician** JUNE 12, 8:20P M MILDRED DOLORES /Medical 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Days | Hours | Min. | Dec. 9, 1934 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2√2 F Maryland 72 218-30-8947 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 X Yes 2 □ No Maryland | Frederick Thurmont 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21788 6 Walnut Street U.S.A. Funeral filed within 72 hours after death 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 🍎 No Baltimore, Maryland 21215-0036 Specify: 9 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ith and Mental Hygiene.
27 is marked other than "
r traumatic event, the Mec Elementary/Secondary (0-12) College (1-4or 5+) Custodian Community College 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Roy William Lookingbill Mabel Fogle 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trauonce. 7916 Rocky Ridge Road, Thurmont, MD 21788 Gary Sunday / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Thurmont, Maryland Blue Raidge Cemetery 6/16/07 21. Signature of Funeral Service Licens 22. Name and Address of Facility ROBERT E. DAILEY & SON FUNERAL HOMES, 615 EAST MAIN STREET, THURMONT, MD 21788 23a. Part1. Enter II e disease, or complications that cause of shock, or heart failure. List only one cause of each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) NO 10 VASCULAR **Physician** Theroschenoric /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran-Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 4□Pregnant at time of death 5 Other (specify) ned by the a 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signe þ 1 Yes 2 No 3 Probably 4 Onknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of ate has page 2 s performed death? 1 ☐ Yes 2 ☐ No 2 🗖 No To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ After this 28a. Date of Injury (Month, Day Year) the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1. Natural 5 ☐ Pending investigation nours after death.
Ineral Director: A 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00035152 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thurmond, MD 21758 STREET S. CenTer 100 31. Date filed (Month, State Registrar

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			_ FOI	partment of Health and Mer		0000	0105
- 32	Se The Sec	1	Hegistrar     Decedent's Name (First, Middle, Last)	2.	Reg. I	,	3. Time of Death
	Physicia /Medic		Evelyn J. Stewart	I	June 1	7 2007	1:30 P M
)	Examin		4a. Facility Name (If not institution, give street and number) Southern Maryland Hospital	4b. City, Town, or Location of Death Clinton		4c. County of Death Prince Geo	
E	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	Months Days Hours Min.	Date of Birth (Month, Day, Yes	ar   Cou	place (State or Foreign ntry)
A)	Director		188-28-7875 1	Ma	ay 13 193	35 Bath	, SC
	yland yland at		10a. State 10b. County 10c. City, Town or I				10d. Inside City Limits
	e Mar la-f st tifled	ctor	Maryland Prince George's Forestvil	1e			1X Yes 2 No
	ith th or 28 be no	Director	10e. Street and Number	10f. Zip Code		Citizen of What Cou	-
	sath v	eral	3525 Pinevale Avenue  11 Marital Status 12. Was Decedent Ever in U.S. 13	Was Decedent of Highania Origin? (Specifi		nited Sta	
_	be filed within 72 hours after death with the Maryland ttal Hyglene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🕅 No	. Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Ric	ean, etc.)	Black, White	etc.
22	ours a ral', o Exarr		3 ₩ Widowed 4 □ Divorced	1 ☐ Yes 2M No Specify:		Specify: B1	ack
315-003b	"natu	Completed by	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Given the control of t	edent's Usual Occupation le kind of work done during most of working DO NOT use retired)	16b.	. Kind of Business/Ir	ndustry
7	within ene. <b>than</b> he Me	dmo	Elementary/Secondary (0-12) College (1-4or 5+)	Teacher		Education	
D	i filed Hygi other ent, tl	e C	17. Father's Name (First, Middle, Last)	18. Mother's Name (F	irst, Middle, Maid		
yland	ould be Mental narked o	To Be	Austin Jefferson	Griff	Ein		
Mary	2 should be and Mental is marked raumatic ev	•	G	ling Address (Street and Number or Rural R			•
d)	and lealth m 27 her to			Green Lane - Wyncot		Sylvania 1 Location - City or T	
5	ages int of h		IA Durial 2 Defermation 3 Defermoval from State 1	ematory or other place)		•	
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n	permit. Pages 1 Department of H Important: If ite any injury or ot once.		Matter Sun Molist 5	538 Marlboro Pike, F	orestvil	. nomes, i .le. Marvl	and 20747
Н	7-5		23a. Partit. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.				Approximate Interval Between
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Ķ.	/Medical Examiner		resulting in death)  Due to (or as a consequence of):	(arcinom)			
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	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events				
Ď,	an and	Exa	resulting in death) Last  C.  Due to (or as a consequence of):				
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Š P	atter for u	Physician/Med	in the past 12 months? 1 Live birth 2 Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delive Month	Pery Day Year
j.	t the d by the ached	hysi	9 ☐ Unknown 9☐ Unknown		,		
κ, T	w requires that the death been signed by the atter should be detached for u	by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobaco	co use contribute to	/
ecords,	requir	ted	Anemia		1 ☐ Yes	2 No 3 Pro	bably 4 donknown
S S		Completed	ATRIAL F. Svillation		24a. Was an autopsy	prior to co	opsy findings available ompletion of cause of
<u> </u>	<b>slcian:</b> The law certificate has b irector, page 2 s			156926	performed 1□ Yes 2□		211 No
VII	yslcian: is certific director,	o Be	25. Was case referred to medical examiner?  1   Yes 2   To   Hospital: 1   Inpatient 2   EP/Outpati	26. Place of Death (Content 3 DOA Other: 4 Nursing Home		6 Dother (Gree	MA A
0	는 눈들	n: To	27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at 28d	d. Describe how in		ny)
010	ending F eath. or: After he funera	atio	2 Accident investigation	M 1 Yes 2 No			
UIVISION	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, s building, etc. (Specify)	street, factory, office 28f.	. Location (Street City or Town, St	and Number or Rui ate)	al Route Number,
ב	pital ours a leral L		29a. Certifier 1 Certifying Physician: To the best of my knowledge, de	ath occurred at the time, date and place, and	d due to the cause	e(s) and manner as	hatste
	e Hos 24 hc e Fun letely	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and/or and manner stated.				
	To th withir To th comp	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month	, Day, Year)
	10		15 tillo	D19889	O	6-18-	07
	67		30. Name and address of person who completed cause of death (Item 23a) (Type		62	<b>*</b> C *	200
	Sta	te.	31: That a files (Month Day Year) 32. Registrar's Signature.	8 Southern Ave	J.L.	DC 2	0032
	Registr		JUN 2 I 2001 Statem X. Sperke				
			1111				

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cian: The law requires that the death certificate be executed	To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
TO	#
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	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

	•	For State Registrar		State of Ma	arylan	-	rtment of tificate of	Health and N Death		giene Reg. No.	200	7 21855		
Physicia /Medic	-	1. Decedent's Nam		SAUNDERS					JUNE 19	Day	O7 Year	3. Time of Death <b>7:05</b> P M		
Examin	.36	4a. Facility Name (I	If not institution,	give street and number)		-	4b. City, Town,	or Location of Death		4c. C	ounty of Dea	th		
		BRADFORI	OAKS N	URSING HOME			CLINT	ON		PR	INCE G	EORGES		
Funeral		5. Social Security N	lumber 6			ast birthday)	If Under 1 Year Months Days		8. Date of Birl (Month, Da	h v. Yea <i>r</i> )	9. Bir	thplace (State or Foreign ountry)		
Director		578-16-52		1□ M 2 <b>X</b> JF	88	Yrs.			JANUARY	9 <b>, 19</b> 1	9 WAS	HINGTON, DC		
at		Usual Residence of 10a. State	10b. County		10c. City	, Town or Lo	cation					10d. Inside City Limits		
if st	호	MD	PRINCE	GEORGES	UPF	PER MAI	RLBORO					1 X Yes 2 □ No		
noti	Director	10e. Street and Nu					10f. Zip Code			10g. Citize	n of What Co	ountry?		
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mus 2	Funeral	11. Marital Status	III IIAKWO	12. Was Decedent		S. 13. \		Hispanic Origin? (Sp	ecify Yes or No		ED STAT			
iner	<u>.</u>		ried 2□ Marrie	Armed Forces? d 1 □ Yes 2 <b>Y</b> □	No			Hispanic Origin? (Sp ban, Mexican, Puerto	Rican, etc.)		Black, Whit	e, etc.		
xam xam	þ	3 ☐ Widowed		d 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:			I∐Yes 2∭XNo	Specify:		S	pecify: Bl	LACK		
al E			15. Decedent's	1	- 1	16a. Deced	lent's Usual Occu	pation		16b. Kind	of Business			
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thar he M	Ĕ	Elementary/Seco	ondary (0-12)	College (1-4or 5	5+)		HEALTH .			MI	EDICAL			
nt, the		17. Father's Name	(First Middle I	act)				18. Mother's Name	e (First Middle					
Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Be		•	431)				1			,	NED 6		
Mer arke	유	JOHN SAU				1		MELISSA (						
and is m		19a. Informant's N				19b. Mailin	g Address (Stree	t and Number or Rui	ral Route Numb	er, City or T	own, State, 2	Zip Code)		
ertr		CHERYL S	SHORT/GR	ANDDAUGHTER		3898	NORTH G	ATE PLACE,	WALDOR	F, MI	20602	2		
oth ite		20a. Method of Dis			20b. P	lace of Dispo	sition (Name of natory or other pla		Date	20c. Loca	tion - City or	Town, State		
or # c			□Cremation : 5 □ Other (Specific Control Cont	3 ☐Removal from State		-	N CEMETER	1	72007	BREN	TWOOD.	MD		
artm ortar injui	ŀ	21. Signature of Fu			LOIC						I WOOD,	TID .		
an y p		TAUL			ON AA	) ) ) ) ()	HORNTON	FUNERAL H	HOME, P.	A.				
		220 Porti Enteri	the disease ere	RNTON JOHNS	ON 1416	Do not ont	3439 1.1V	INGSTON RO	DAD, IND	IAN F	IEAD, N	D 20640 Approximate		
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t by	Physician/M	9 Unknown		1		III - 1 - 2			00 51					
gned be de	þ	2		ns contributing to death b	ut not resu	ilting in the ur	nderlying cause g	iven in Part I.				o the cause of death?		
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s bec	Completed	HU	perter	Maile					24a. Was	an	24b. Were at	utopsy findings available		
e has	Ĕ	1,1	PCI ICI	101011					autor perfo	rmed?	prior to death?	completion of cause of		
ficati r, pa		05 Mc2	red to '''						1□ Yes	2 No	1 ☐ Yes	2 No		
certi	Be	25. Was case reference examiner?		Hospital:				26. Place of Deat						
this al dir	유	1 ☐ Yes 2	•	1 🔲 Inpalie		ER/Outpatien	1 3 DOA	4 🔼 Nursing Ho	ome 5 Resid			ocify)		
After	ü	27. Manner of Deat	5 Pending		Year)	28b. Time of Injury	Wo	ork?	28d. Describe I	now injury	occurred			
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rect by t	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could no determin		ury - At ho	me, farm, str	eet, factory, office		28f. Location (5 City or Tox		Number or R	ural Route Number,		
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	Medical (	29a. Certifier (Check only one)		Physician: To the best xaminer: On the basis o and manner st	f examinat									
omp	Me	29b. Signature and	title of certifier	) 2			29c. Licen	se number		29d. Date	signed (Mont	th, Day, Year)		
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Registra	ar		JUN 2 1	2007 Buch	2	& A	met !							
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			100	partment of Health and Me	ental Hygie	ene on our olong
				ertificate of Death		No. CUU 2 1001
	Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year
1	/Medic		Clifton B  4a. Facility Name (If not institution, give street and number)	Stewart 4b. City, Town, or Location of Death	June 1	4, 2007 3:00 a M
	Examin	er	9504 Westphalia Road	Upper Marlboro	)	Prince Georges
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthd		8. Date of Birth	9. Birthplace (State or Foreign
	Director		214-28-4704 XXII 2□F 78 Yrs	World Days Hours Will.	05/07/1	1929 Maryland
	and w		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits
	h the Maryland or 28e-1 ehow	ţ	Maryland Prince Georges Upper	Marlboro		tX Yes 2 No
	ith the	Directo	10e. Street and Number	10f. Zip Code	10g.	. Citizen of What Country?
	death with the Maryland ims 23a or 28e-f ehow Fittust be notified at		9504 Westphalia Road	20774		USA
	tems	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	<ol> <li>Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto F</li> </ol>	cify Yes or No- lican, etc.)	14. Race - American Indian, Black, White, etc.
36	hours after tural, or ite	by F	1 ☐ Never Married 2 Married 1 Yes 2 ☐ No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:1 Q 5 2 5 6	1 ☐ Yes 2X No Specify:		Specify: Black
2-003	72 hours natural', lical Ext		15. Decedent's Education 16a. De	cedent's Usual Occupation	161	b. Kind of Business/Industry
212	within 72 ene. than "net	Completed	(Specify only highest grade completed) (G Elementary/Secondary (0-12) College (1-4or 5+)	ive kind of work done during most of working. DO NOT use retired)	g	,
7	filed wit Hygiene other the	Соп	12 Pla	te Printer		ederal Government
Maryland	be fill htal H even	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Mai	
چّ	hould d Mer marks matic	٥	Unknown  19a. Informant's Name/Relationship (Type, Print)  19b. M	Anne	Davida Museban O	Stewart
<u>S</u>	s 1 and 2 shoul f Health and M ftem 27 is marl other traumati			alling Address <i>(Street and Number or Rural</i> 4 Westphalia Rd. U		
ē,	s 1 and f Health ftem 27 other t		20a. Method of Disposition 20b. Place of Di			c. Location - City or Town, State
Baltimore,	8°= 5		TE Denial 2 Goldmation o Chromoval nom State	nd Veterans 6/22	/07 Ch	eltenham,Maryland
<u>a</u>	permit. Pag Department Important: any Injury once.		21. Signature of Fuderal Service Licensee	22. Name and Address of Facility Ada	ms Fune	eral Home PA
n	88 = 8			0605 Aquasco Rd.	Aquasc	o, Maryland 20608
			23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or head failure. List only one cause on each line.	enter the mode of dying, such as cardiac or	respiratory arrest,	Interval Between
}	Physician		Immediate Cause (Final disease or condition resulting in death)	wife conder un	stylas	Angua 5 ms
E	/Medical Examiner		Due to (or as a consequence of):	mie Continua		
		ē	Sequentially list conditions, if any, leading to immediate b. Due to (oras a consequence of):	nul molum	uly "	Ineme
	uted d ansit	Examin	cause. Enter Underlying	Audimi !		
Š	be executed sicien and burial-transit	Exa	resulting in death) Last Due to (or as a consequence of):			
8/60	cate be execul physicien and the burial-trar	dicai	d			
٥	ding p	0	IF FEMALE:			
X Q	es that the death certification of the detached for use as	Physician/M	In the past 12 months:	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery  Month Day Year
o.	the d	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	o to their (specify)		
 J	requires that een signed b hould be deta	by PI	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death?
Hecords	w require been sig should b	edt	Consission, prostate		1 ☐ Yes	2⊠No 3 Probably 4 Unknown
ပ္ပ	aw as b	piet			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
	The ate h page	Completed			performed	d?   death?
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	26. Place of Death	Check only one	
0	Physic this c	<u>۲</u>	1			e 6 Other (Specify)
sion	ding h. Atter	tion	1 Natural 5 Pending (Month, Day Year) Injur 2 Accident investigation		3d. Describe how i	injury occurred
	Atten r dea ector by the	fica	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm,		8f. Location (Stree	at and Number or Rural Route Number,
<u>≥</u>	s afte	Certification:	4 ☐ Homicide determined building, etc. (Specify)		City or Town, S	itate)
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	edicai	29a. Certifier 1 ☐ Certifying Physician: To the best of my knowledge, di 2 ☐ Medical Examiner: On the basis of examination and/oi	eath occurred at the time, date and place, an	nd due to the caus	e(s) and manner as stated.
	the f	Med	one) and manner stated.  29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)
)	유통다		Manfam M			
			30. Name and address of cerson who completed cause of death (Item 23a) (Temperature of the complete of the com	Print		7.701
	353		33.4	nn 12 #18 4	T.EP M	6/18/07 halbord MD 2017
	Sta		31. Date filed (Month, Day, Year)  32. Registrar's Signature	Acres de la		/
	Registr	ar	JUN 2 1 2001 James 100 /			

			1 - For State Registrar	State of Mar		artment of H			giene 2	007	21050
ı	Physici		1. Decedent's Name (First, Middle, La Shirley	E .		Stewa	art	2. Date of Dea Month June	Day	2007	3. Time of Death 07:20 M
	/Medic Examir		4a. Fecility Neme (If not institution, giv	e street and number)		4b. City, Town, or	Location of Dea			nty of Death	07.20
			13002 Chalfor	nt Ave.		Fort Wa	shinat	.on	Prin	ce Ge	eorge
	Funeral		5. Social Security Number 6. S	Sex 7. Age (	In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs		h Vozel	9. Birthpl	ace (State or Foreign
и.	Director		272-28-7001	□M 20 <b>X</b> F	75 Yrs.	Months Days	Hours Min	8. Date of Birth (Month, Day 05/13/	1932	Oh i	
	p ,		Usual Residence of Decedent		0.00						
	aryla shov	_	10a. State 10b. County		Oc. City, Town or Lo					10	0d. Inside City Limits 1  1  1  1  1  1  1  1  1  1  1  1  1
	Ba-f	Director	Maryland Prince	George	Fort Was						
	with t	声	10e. Street and Number	_		10f. Zip Code			10g. Citizen o		try?
	e 23	Funeral	13002 Chalfont			2074			US		
	lter d	'n	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Even Armed Forces? 1 ☐ Yes 2 🖺 No	er in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	n, Mexican, Puer	to Rican, etc.)	I4. Hi	ace - America lack, White, e	
38	irs af	by F	3X Widowed 4 □ Divorced	If Yes, Give		1 ☐ Yes 2🛣 No	Specify:		Spec	ify: Bla	ck
ğ	should be filed within 72 hours after death with the Maryland not Mental Hyglene. I marked other than "natural", or Iteme 23e or 28e-f show umatic event, it a Medical Examinar must be notified at	ed	15. Decedent's Ed	ducation	16a, Dece	dent's Usual Occupa	ation			Business/Ind	
Maryland 21215-0036	n n	Completed	(Specify only highest gra	ide completed)	(Give	kind of work done of DO NOT use retired	during most of wo	orking		20011000	
2	d with	E	12	College (1-4or 5+)	Но	memaker			Domes	tic	
ਰੂ	othe	Be C	17. Father's Name (First, Middle, Last)	)			18. Mother's Na	me (First, Middle,	Maiden Suma	ame)	
<u>a</u>	Aenta Aenta rked ric e		William A		Johns	ton	Cather	lean		Bur	awin
ar	and he		19a. Informant's Name/Relationship (	Type, Print)	19b. Mailir	ng Address (Street a			r, City or Tow		
Σ	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if Item 27 is marked other than "natural", or Iteme 23s or 28s-f show any injury or other traumatic event, the Mudical Examiner must be notified at ance.		Byron Stewart/	' Son							Maryland
ore.	of He		20a. Method of Disposition		20b. Place of Dispo cemetery, crer			Date	20c. Location		
Ĕ	Page nent int: ff		1  Burial 2  □ Cremation 3  □ 4  □ Donation 5  □ Other (Specification	in ionioval noni state	Arlingto			03/07 A	rling	ton.V	/irginia
altimore,	mit. partn ports y inju	1	21. Signature of Juneral Service Licer	see	22	2. Name and Addres	s of Facility A d	ams Fun	eral	Home	PΔ
m	80 5 8	10 4	1 Zan S		191 20	0605 Aqu	iasco R	oad Agu	asco,	Maryl	and20608
Н			23a. Part1. Errier the disease, or com shock, or heart failure. List only	plications that caused th						Ī	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		Mycardi	al Infa	rction				Onset and Death
-	/Medical		resulting in death)	a	consequence of):	.42 11114	1001011			-	
	Examiner		- Washington Color (Washington)	Cardi	ovascula	r Disea	se				
		ner	Sequentially list nonditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a c	consequence of):						
	requires that the death certificate be executed been signed by the ettending physicien and hould be detached for use as the burial-transit	Examiner	that initiated events	с.							
o	e exe	Ä	resulting in death) Last	Due to (or as a c	consequence of):						
8760,	ate b	dicai		d						li con	
9	ng pt	Zed	IF FEMALE:					_			
Š	leath certific ettending p	an/I	23b. Was decedent pregnant	23c. If yes, outcome of		Ectopic pregnancy				ate of deliver	•
B	e dea he et ed fo	sici	in the past 12 months? 1 Yes 25to	4☐Pregnant at tim 9☐Unknown		Other (specify)			N	fonth I	Day Year
J Ö	at the	Physician/Me	9 Unknown								
ທົ	res that the de signed by the e be detached i	þ	Part II. Other significant conditions of				en in Part I.				e cause of death?
ord G	v requir been si should I	ted	Coronary Art	ery Diseas	se, Iisc	hemic		1 🗆 Y	es 2⊠No	3 🗌 Proba	ıbly 4 ∏Unknown
ပ္ခ		Completed	Cardiomyopathy	S/P ICI	) 5/F	CABL	SIP PL	24a. Was a		. Were autop	sy findings available
<b>x</b>	The law cate has page 2 a	ρ						perform	med? 2 🔀 No	death?	pletion of cause of
Vital Records,	siclan: Th certificate rector, pag	Be (	25. Was case referred to medical examiner?				26. Place of Dea	ath Check only on			
	Attending Physician: It death.  •ctor: After this certific by the funeral director.	2	1 ☐ Yes 2 🙀 No	Hospital: 1 ☐ Inpatient	2 ER/Outpatien	t 3□ DOA Othe	4 Nursing H	lome 5 🔀 Reside	ence 6 🗆 Ot	ther (Specify)	)
_	ding P h. After t funera		27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Y	28b. Time of Injury	28c. Injury Work	at ?	28d. Describe ho	ow injury occu	urred	
010	uttendi death. ctor: A y the fu	ati	2 ☐ Accident investigation				res 2□No				
Division of	2 P - C	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (	<ul> <li>At home, farm, stre Specify)</li> </ul>	eet, factory, office		28f. Location (Si City or Town		nber or Aural	Route Number,
	urs el										
	To the Hospital of within 24 hours of To the Funaral D completely filled in	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of n niner: On the basis of ex	amination and/or inv	occurred at the time restigation, in my op	e, date and place inion, death occu	a, and due to the caured at the time, d	ause(s) and mate and place	nanner as sta , and due to	ited. the cause(s)
	To the within 2 To the complet	Med	29b. Signature and title of certifier	and manner stated	J.	00-15					
)	5 ± ₹ 5		15 10	ERICH	ACCOM	m Virginiz	1017271	2/17	9d. Date sign	\$ 100 min	37.
			Cruestille	our	MD	5 6	11012348	876 U	VIVE 1	0,200	14
3	EIN		30. Name and address of person who defined for the ERICH FWEDAM	completed cause of deat	MD h (Item 23a) (Type, \$CONSIN)	Print)	NT 0 - 1.	(0,0===1)	REUR	The M	10 7000
4	Sta	te	31. Date filed (Month, Day, Year)	32. Pegistrar's	Signature	NAG DC	101- 611	WIUZOGY	DEINE.	-un, IV	20007
17	Registr		JUN 2 1		· K A	make a					

			For State Registrar	5	tate of Mar		ertificate of		and Me		giene	007	21859
*漢	Physicia		1. Decedent's Name (/	First, Middle, Last) Frank Scl	neyett				4	2. Date of Dea Month	Day	2007	3. Time of Death 22:08 M
	/Medic Examin		4a. Facility Name (If no	ot institution, give stre	et and number)		4b. City, Town,	or Location o	of Death		4c. C	ounty of Death	
			Prince Ge	orge's Ho			Chever					nce Geo	
	Funeral Director		5. Social Security Num 718-18-038	5 1 <b>6</b> M		ln yrs. last birthda 88 Yrs.	Months Days		Min.	B. Date of Birt (Month, Date 01-10-1	h y, <i>Year)</i> 1919	9. Birthp Coun Washi	lace (State or Foreign htry) ngton, DC
land	ow II		Usual Residence of De 10a. State 1	ecedent 0b. County	1	Oc. City, Town or	ocation					1	0d. Inside City Limits
Many	a-f sh illed	tor	MD 1	Prince Geo	rge's	Hyatts	ville						1 ▼ Yes 2 □ No
death with the Maryland	or 28 De no	Funeral Director	10e. Street and Number				10f. Zip Code	0784			•	n of What Coun	itry?
eath v	ns 23e	erai	3703 65th		Was Decedent Ev	er in U.S. 13			gin? (Spec	ify Yes or No		. Race - Americ	
ter	artment of Health and Mental Hygiene. ortant: If Item 27 is marked other then "natural", or Items 23a or 28a-f show injury or other traumatic avent, the Medical Examiner must be notified at g.	by Fun	1 ☐ Never Married	2 Married	Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		. Was Decedent of tf Yes, specify Cul 1 ☐ Yes 2 ☒ No		ĭ, Puerto R	ican, etc.)		Black, White, pecify: Wh	etc. i <b>ite</b>
6 13-0030 thin 72 hours al	nature lical E			5. Decedent's Educat		16a. Dec	edent's Usual Occu	upation e during most	t of working	g		of Business/Inc	
within	then "	Completed	Elementary/Second		College (1-4or 5+)		re kind of work done DO NOT use retire Brakeman	ed)			Washi	ngton 1 Railroa	erminal d
be filed	and Mental Hygiene. Is marked other then aumatic avent, the Me	Be C	17. Father's Name (Fi			1				(First, Middle,			-
aryland should be file	Menta varked vatic a	To		dt F. Sche			(2)			Elnora			Codel
	Ith and 27 is rr traurr		19a. Informant's Nam Patricia M				iling Address (Stree Byrd Mil	_					
MOFE, N	nt of Hea t: if item y or other		20a. Method of Dispos 1 🔀 Burial 2 🔲		aval from State		position (Name of ematory or other place)		Da -6-23			ation - City or To	
	Department of important: If it any injury or once.		21. Signature of Fund				22. Name and Addi						, MD 20781
di A	- 10		23a. Part 1 Enter the	disease, or complica failure. List only/one/	ions that caused the	ne death. Do not e	nter the mode of dy	ing, such as	cardiac or	respiratory a	rrest,		Approximate Interval Between
	nysician		Immediate Cause (Findisease of condition	7 //		SEV	1110	SH	OCI	K			Onset and Death
	Medical kaminer		resulting in death)		Due to (or as a	colise puence on:	1401	ULA					
77		ner	Sequentially list cond if any, leading to imm cause. Enter Underly Cause (Disease or injurat initiated events	itions, b ediate ring b	Due to (or as a	consequence of);	EMIC	· /	(0)	IIT	15		
<b>5U,</b> be executed	and I-trans	Examiner	Cause (Disease or inj that initiated events resulting in death) Las	jurý st	Due to (or as a	consequence of):	CMI			_ [ ]	()		
( Pe Pe	S CO	calE		d	`								
	ing phy easth	Medi	IF FEMALE:										
J. BOX 68 e death certifica	he attending phy ied for use as th	Physician/Med	23b. Was decedent p in the past 12 m 1 Tes 2 T	onths?	If yes, outcome of 1 Live birth 2 4 Pregnant at tir 9 Unknown	Fetal death	Ectopic pregnan	су			23	d. Date of delive Month	ery Day Year
That the C	de p		9 ☐ Unknown  Part II. Other signification	ant conditions contri	buting to death but	not resulting in the	underlying cause g	given in Part I		23e. Did t	obacco use	e contribute to the	he cause of death?
OrdS, P.	should be	ed by								1 🗆	Yes 2□	No 3 ☐ Prot	oably 4 Junknown
Hec be aw	S D	Completed								24a. Was auto perfo	psy ormed?	24b. Were auto prior to co death? 1 \(\sum \text{Yes}\)	opsy findings available impletion of cause of
_	certificate ha	BeC	25. Was case referred examiner?							Check only	on <i>e</i> )		
OT VITA Physician:	this ce al dire	၉	1 ☐ Yes 2 個 No	0		2 ER/Outpat						Other (Specif	(y)
SION (	After tune	tlon:	27. Manner of Death 1 Natural 2 Accident	5 Pending investigation	28a. Date of Injury (Month, Day	Year) 28b. Time Injur	/ W	uryat ork? ∐Yes 2. ☐		8d. Describe	now injury	occurred	
<b>5</b> ₹		Certification:	3 Suicide 4 Homicide	6 Could not be determined	28e. Ptace of Injury building, etc.	y - At home, farm, (Specify)	street, factory, office	e	2	8f. Location ( City or To		Number or Run	al Route Number,
UI • Hospital or	within 24 hours after of the Funeral Directompletely filted in by	ica	(Check only 2	Certifying Physic  Medical Examine	r: On the basis of e	xamination and/or	investigation, in my	opinion, dea	ath occurre	d at the time,	date and p	place, and due to	o the cause(s)
To the	To the comple	Me	29b. Signature and it	the appendier	MD		29c. Lice	nse number	580		29d. Date	signed (Month, 20 200	Day, Year)
	5/7		29b. Signature and aid address 1. Date filed (Month.)	s of person who com	pleted cause of dea	ath (ttem 23a) (Type	Print) Driv	e, C	heu	erly,	MD	2078	?5.
É		ate	31. Date filed (Month,	, Day, Year)	32. Registrar	's Signature							
	Regist	rar	וטנ	N Z I ZUU/	Deren	M. So	ande				_		

DHMH 17 Rev 1/2001

ORIGINAL

			For	State	of Maryla		artment of F		nd Men	tal Hy	giene		
			1 - State Registrar			Ce	rtificate of	Death	10.		Reg. No.	200	7 2 350
	Physicia /Medic		1. Decedent's Name (First, Middle Stephen To	e, Last) ong						Date of De Month une ]	Day	007 Year	3. Time of Death  10:10 a M
3	Examin		4a. Facility Name (If not institution	n, give street and	number)		4b. City, Town, o	r Location of D	Death		4c. (	County of Dea	ath
9			Collingswood 1	Nursing	Home	1	Rockville					Montgo	mery
	Funeral		5. Social Security Number	6. Sex		s. last birthday)	If Under 1 Year Months Days		Hrs. 8. [	Date of Bir (Month, Da	th y, Year)	9. Bi	rthplace (State or Foreign Country)
ы	Director		126-42-7576	1 🗽 M 2 🗆 F	56	Yrs.				1y 20		50	China
	pu »		Usual Residence of Decedent  10a. State 10b. County		10c C	City, Town or Lo	ncation						10d. Inside City Limits
	anyla shov	'n	Toa. State Tob. County		100. 0	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,							1 □Yes 2 □No
	he M 18a-f otifie	Director		tgomery	Sil	ver Sp					10a Citiz	en of What C	Country?
	with t	Dir	10e. Street and Number 1706 Dublin	Drive			10f. Zip Code 2090	12			•		ountry:
	s 23g	Funeral			Decedent Ever in	118 12	Was Decedent of H		2 (Specify	Ves or No		ISA 4. Race - Am	erican Indian.
	item item ner r	'n.	<ol> <li>Marital Status</li> <li>Never Married 2         ✓ Married</li> </ol>	Armed	Forces? es 2 🛣 No	0.3.	If Yes, specify Cub	an, Mexican, F	Puerto Rica	in, etc.)		Black, Whi	
36	be filed within 72 hours after death with the Maryland ital Hygiene. A other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by F	3 Widowed 4 Divorced	If Yes.	Give or Dates:		1 ☐ Yes 2 🙀 No	Specify:				Specify: A	sian
21215-0036	thou atura	ed	15. Deceden	t's Education		16a. Dece	dent's Usual Occup	oation			16b. Kin	nd of Business	s/Industry
15	nin 72 n "na Medik	Completed	(Specify only highe Elementary/Secondary (0-12)		ed) je (1-4or 5+)	(Give	kind of work done DO NOT use retire	during most of d)	f working				
2	d within giene.  r than " the Mec	E	District Raily Geodinary (6 12)	5+			Architect					N.I.H.	
b	e filed within al Hygiene. I other than ' vent, the Me	Be C	17. Father's Name (First, Middle,	Last)				18. Mother's	Name (Fil	rst, Middle	, Maiden S	Surname)	
Maryland	2 should be and Mental is marked or aumatic eve	To E	Ah Wing Tong					Beck Q	uan F	'ung			
ary	sho and h s ma	l i	19a. Informant's Name/Relations	1,177		1	ng Address (Street				-		
	and 2 salth 27 i		Cathy C. Lonas	3/Wite		170	5 Dublin	Drive,		er Sr	ring	, MD 2	0902
altimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any Injury or other traumatic es once.		20a. Method of Disposition 1 ☐ Burial 2 <b>XX</b> remation	3 □Removal fr		Place of Dispo cemetery, cre	osition (Name of matory or other pla	ce)	Date	_	20c. Loc	cation - City o	r Town, State
Ē	Pages ment of I ant: If its ury or o		4 □ Donation 5 □ Other (5			tropol	itan Crom		une 2 200	_	Alex	andria	, Virginia
at	Departi Departi Import any Inj once.		21. Signature of Funeral Service		7 /	2	itan Crom 2 Name and Addre 1 rancis J	ess of Facility COIL:	ins F	unera	al Ho	me Inc	•
<u>m</u>		1	1 Cinche	~ 7 -	eve		500 Unive	rsity	Blvd.	W.,	Silv		ing MD 20901
п			23a. Part1. Enter the disease, or shock, or heart failure. List	complications the only one cause (	at caused the de on each line.	ath. Do not en	ter the mode of dyi	ng, such as ca	ardiac or re	spiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician	h 7	Immediate Cause (Final disease or condition	, Non	-Hodgkin	s Lympl	noma						Onset and Death
	/Medical		resulting in death)		to (or as a conse								
В	Examiner		Sequentially list conditions.	b. Fai	lure To	Thrive							
	Pa ÷	ine	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events	Due	to (or as a conse	equence of):							
	ecute and trans	Examine	that initiated events resulting in death) Last	C	to for an a cons	anana of:							
8760,	cate be executed physician and the burial-transit	<u> </u>	, , , , , , , , , , , , , , , , , , ,	Due	to (or as a conse	equence or).							
87(	cate b	dical		d									
9	eath certific attending p I for use as	a a	IF FEMALE:	200 Hyes	outcome of prog	inanov.						illa la secono	200
Box	ath c	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 □Li	outcome pf preg	etal death 3	⊒Ectopic pregnanc ⊒ Other (specify)	;y			2	3d. Date of do Month	elivery Day Year
	the s	ysic	1 Yes 2 No 9 Unknown		regnant at time o nknown	rgeam 5	Other (specify) _						
P.0	that the de led by the a		Part II. Other significant conditi	ons contributing	to death but not re	esulting in the u	ınderlying cause gi	ven in Part I.		23e. Did	tobacco u	se contribute	to the cause of death?
dS,	36 JL 96	by	•				, ,			1 🗆	Yes 2	XINo 3□F	Probably 4 ☐Unknown
Ö	w require been się should b	Completed								04-14		0.41- 141	- Last Cadinas available
3ec	2 SS 2	du du				<u>.</u>				24a. Was		prior to	autopsy findings available o completion of cause of
a	(0 -	Ö								1 Yes	2 <b>X</b> No		es 2 No
Z:	slcian: certific rector,	Be	25. Was case referred to medica examiner?	Hoepital			l Ott	26. Place of					
0	Physician: this certific	2	1 ☐ Yes 2★ No  27. Manner of Death	1	i ☐ Inpatient 2 late of Injury	☐ ER/Outpatie 28b. Time of	III SLIDOA	4 🔀 Nurs				3 □Other (Sp y occurred	pecify)
n	ding n. After funer	io	13 Natural 5 ☐ Pendir	ng <i>(I</i>	Month, Day Year)		Wo	irk? ]Yes 2∐No		. Describe	now injury	y occurred	
isi	Attending r death. ector: After oy the fune	icat	3 Suicide 6 ☐ Could	not be	lace of injury - At	home, farm, st	reet, factory, office			Location (	Street and	d Number or I	Rural Route Number,
Division or Vital Records,	or A after Direction by	Certification:	4 ☐ Homicide detern	lined b	uilding, etc. (Spe	cify)	, oot, idealy, emee			City or To	wn, State	)	
	To the Hospital or Attending Phys within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral di		29a. Certifier 1 ★ Certifyi	ng Physician: To	the best of mv k	nowledge, dea	th occurred at the t	ime, date and	place, and	due to the	cause(s)	and manner	as stated.
	e Hos 24 h e Fui letely	Medical	(Check only 2 Medical one)		ne basis of exami manner stated.	nation and/or i	nvestigation, in my	opinion, death	occurred a	at the time	, date and	l place, and d	ue to the cause(s)
	Fo th within Fo th	₹	29b. Signature and title of certific		/		29c. Licens	-			29d. Dat	e signed (Mo	nth, Day, Year)
	. 21-0		1 -56	ELSON	400h	MC	00	0624	35		Č	June 20	0, 2007
7	30		30. Name and address of person				, Print)				-		
			Sayed ElSayya					ive, #2	201, 1	Rockv	ille	, MD 20	0850
	Sta	ite	31. Date filed (Month, Day, Year,	3	2. Registrar's Sig	nature							
	Regist		JUN 2	1 2007	Molue	1. 6	racks)						

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 🤉 🖺 🦷 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year Joseph Thomas Taylor June 27 2007 8:15 A M /Medical 4c. County of Death 4a. Facifity Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Moran Manor Nursing Home Allegany Westernport | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) | March 21 1917 | West Virginia 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1⊠M 2□F 90 215-10-8021 Yrs **Director** Usual Residence of Decedent the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Peges 1 and 2 should be filed within 72 hours after death with the Marylar ment of Heelth and Mental Hygiene.
ant: If Item 27 ie marked other than "natural", or Iteme 23a or 28a-f ehow ury or other treumatic event, the Modical Examinar must be notified at WV. Mineral Keyser tXXYes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 500 Carskadon Lane, Apt. 403 26726 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Wes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Specify: white Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXIIIo Specify: þ 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Colfege (1-4or 5+) Elementary/Secondary (0-12) Paper Manufacturer Maintenance Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Joseph Wesley Taylor Margaret Ann O'Neill 2 19a. fnformant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas Taylor/ son 87 Lynn St., Westernport, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Depertment of H Important: If ite eny Injury or ot once. 06/30/ 1 ☐ Burial 2 XX remation 3 ☐ Removal from State Cumberland Maryland Cumberland Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2007 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Boal Funeral Home lle 111 Church St., Westernport, Maryland 21562 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finaf Colvance **Physician** disease or condition resulting in death) ew years /Medical Due to (or as a consequence of): Examiner Sequentiafly list conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physicien and for use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed Exam Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ 1 Yes 2 No 3 Probably 4 Winknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has birector, page 2 s performed 1 ☐ Yes 2 No After this certification funeral director, p 25. Was case referred to medical Be 26. Place of Death | Check only one) Other: 4 Aursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Marrier of Death 28b. Time of 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: After completely filled in by the fun 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide o the Hospitel 1.7 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 25638 30. Name and address of person who complet of cause of death (ftem 23a) (Type, Print) 21502 aVA Marylang Brondwerk 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 2 7 Registrar 2007

			For State Registrar	State of				t of He	ealth and		tal Hygi	ene g. No. 2	007	21868
	Physici		1. Decedent's Name (First, Middle, La					**		N	Date of Death	Day	Year	3. Time of Death
	/Medic Examin		Betty Jane TARS  4a. Facility Name (If not institution, gi		er)		4b. City,	Town, or I	ocation of De		unt	4c. Coun	agoot ty of Death	,,,
	LAMINI		Western Maryland			er	Hage	ersto	wn			Washi	ngton	
1	Funeral			Sex 7. 1 ☐ M 2 🖫 F	Age (In yrs.	last birthday)	If Under Months	1 Year Days	If Under 24 H	Hrs. 8. D	ate of Birth Month, Day,			lace (State or Foreign try)
Ž.	Director		220-28-8656 Usual Residence of Decedent	W ZA	73	Yrs.				Ma	arch 7	1934		
	yland 10W		10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation						10	0d. Inside City Limits
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or items 23s or 28s-f show any injury or other traumatic event. I'm Medical Exactinat must be notified at ODGs.	rector	Maryland Washi	ngton		Hagers	town 10f. Zip	Code			10	g. Citizen o	f What Coun	1 ☐ Yes 2X No
	h with	a D	16405 Mt. Tabor	Road				2174	0			USA	4	
i	ems ?	ner	11. Marital Status	12. Was Decede	as?	l.S. 13.	Was Dece		panic Origin? , Mexican, Pu	(Specify	Yes or No-	14. Ra	ace - Americ ack, White,	
920	ral, or ite	by Fu	1 ☐ Never Married 2 ☑ Marned 3 ☐ Widowed 4 ☐ Divorced	1 Tes 2 If Yes, Give Year or Date	X No		1 🗆 Yes				.,,	Spec	ihe	ite
215-0	within 72 hours ene. then "natural", the Medical Eve	Completed by Funeral Director	15. Decedent's E (Specify only highest gas Elementary/Secondary (0-12)	Education rade completed) College (1-4	or 5+)	16a. Dece (Give life.	dent's Usu kind of wo DO NOT u	al Occupat rk done du se retired)	ion iring most of	working	1	6b. Kind of	Business/Ind	lustry
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nd	be file	Be	17. Father's Name (First, Middle, Las	t)					18. Mother's I	,		aiden Suma	am <i>e)</i>	
Z S	d Mer narke	ဥ	Albert Masser  19a. Informant's Name/Relationship	(Tuna Briat)		10h Maili		/Ctranta	Carle			City or Town	- Chita Tia	Codel
Sus, Maryland	d 2 sho th and 27 is mu traum		William Tarsus				_		nd Number or					nd 21740
	of Health item 27 other tra		20a. Method of Disposition			Place of Dispo	sition (Na	ne of		Date			1alyla 1 - City or To	
$\mathcal{A}_{\mathcal{A}}$	Pages nent of int: if it		1  Burial 2  Cremation 3 ( 4  Donation 5  Other (Spec		110	dar Lav				8/07	н	agers	town.	Maryland
a iii	permit. Departmine imports Imports ony inju		21. Signature of Funeral Service Lice	ensee	, , , ,		2. Name ar				ich F			riary rana
_	8988		Walut BR.	eli									Maryl.	and 21740
	Physician Physician		23a. Part1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition	y one cause on eac	sed the dear h line.		ter the mod	le of dying	such as card	diac or res	piratory arres	st,	v	Approximate Interval Between Onset and Death VEEKS
	/Medical Examiner		resulting in death)		as a consec								•	VOC KO
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	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a consec	luence of):								
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ão	v requires that the death certitica been signed by the attending ph should be detached for use as th	Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outco 1 ☐ Live birt!	n 2 ☐ Feta	al death 3[	_ Ectopic pi						ate of delive	ry Day Year
o.	the a	ysic	1 Yes 2 No	4□Pregnan 9□Unknow		leath 5	Other (sp	pecify)						- Ly
ď.	that the ed by detac	/Ph	Part II. Other significant conditions	contributing to deat	h but not res	sulting in the u	nderlying o	ause giver	n in Part I.		23e. Did toba	cco use co	ntribute to th	e cause of death?
rds	quires n sigr ald be	q p	HEPATO CELL	MAR	CAN	CER				_	1 🗌 Yes	2 DNo	3 Prob	ably 4 Unknown
၀	aw requires been si	Completed by	DIABETES 1	MELLITU	5						24a. Was an		. Were autor	osy findings available
Ä	The tate he	mo								_	autopsy perform 1 ☐ Yes 21	ed?	death?	npletion of cause of 2□ No
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of \	Physi this c al dire	2	1 ☐ Yes 2 No  27. Manner of Death	Hospital: 1 Mnp		ER/Outpatier			4   Nursin		5 Residen			')
u o	ding h. After funer	tlon	1 Natural 5 Pending 2 Accident investigate	28a. Date of (Month,	Day Year)	Injury	M	28c. Injury Work? 1 □ Y	es 2 No	28u.	Describe how	injury occi	1119Q	
Division of Vital Records, P.O. Box	Atten ector: by the	Certification:	3 Suicide 6 Could not determined	be 28e. Place of	Injury - At h	ome, farm, str	reet, factor				ocation (Stre		nber or Rura	l Route Number,
Ö	ital or A	Ceri		Danding	, etc. (opecin	97				`		Jiato)		
	To the Hospital or Attending Physician: The law requires that the death certitica within 24 hours etter death.  To the Funeral Director: After this certiticate hes been signed by the attending phy completely tilled in by the funeral director, page 2 should be detached for use as it	Medical	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	<b>'hysician:</b> To the be iminer: On the basi and manner	s of examina	owledge, deatl ation and/or in	h occurred vestigation	at the time , in my opi	, date and pl nion, death o	ace, and d ccurred at	tue to the cau the time, dat	ise(s) and n e and place	nanner as sta , and due to	ated. the cause(s)
	To the within To the comp	Me	29b. Signature and fittle of certifier			1 4 -		c. License			296	d. Date sign	ed (Month, L	Day, Year)
	18,		> lun			MO	L	0006	289	5		JUNE	25,8	2007
	4		30. Name and address of person who			-	Print)	1500	Penns	y1van			,	
-	1	100	31. Date filed (Month; Day, Year)	m. Dal	ey , r	m, D,	and I	Hage	rstown	, MD	21742			
	Sta Registr		HISLO 5 2	2007	9245H 1	O. So	RNIN							

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day WILSON 18, 8:21A PEARL JUNE 2007 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death FREDERICK FREDERICK FREDERICK MEMORIAL HOSPITAL 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In vrs. last birthday Days 1□ M 2M -44-2239 VIRGINIA Usual Residence of Decedent 10c. City, Town or Location 10a, State 10d. Inside City Limits 1 Yes 2 No Frederick Frederich 10f. Zip Code 10g. Citizen of What Country? 21703 SwallowTail USA . Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: BLACK Specify. If Yes, Give Year or Dates: 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOSPITAL PRIVATE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Jones ETITIA 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Bural Route Number, City or Town, State, Zip Code) HAMPTON Swallowtail DAU 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State GATES OF HEAVEN LUCY SOUNGS JUNG 25, 2007 SI 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signatule of Funeral Service License WEST Si MICH 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart/failure. List only one cause on each line. Immediate Caus inal disease or condition MYOCARDIAL INFARCTION minute resulting in death) Due to (or as a consequence of): THEROSCIEROSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dead 4 ☐ Pregnant at time of death 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month 5 Other (specify) I□Yes 2□No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2□ No 20 No 1 Tyes 26. Place of Death (Check only one)

**Physician** /Medical Examiner

Physician

/Medical

Examiner

**Funeral** 

Director

a or 28a-f show t be notified at

items 23a

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Important: If ite
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Funeral Director

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Pages 1 and 2 should be filed within 72 hours after death with

Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

attending physician for use as the buria this s after death.
II Director: After this
of in by the funeral d

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

Examiner Completed by Physician/Medical Be 2 Certification: Medical

1)	M		-11
25. Was case examiner? 1 ∐ Yes		/	medical

27. Manner of Death 5 ☐ Pending investigation 2 Accident 6 ☐ Could not be 3 Suicide determined 4 Homicide

1 Inpatient 28a. Date of Injury

2 ER/Outpatient 3 □ DOA 28b. Time of (Month, Day Year)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work?

29c. License number

04686

1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

PREDERICK

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State) Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

NO 21707

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier A Hussin

31. Date filed (Month, Day, Year)

29a. Certifier

29d. Date signed (Month, Day, Year)

200

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 195

2 2007

HUSSAIN

32. Fegistrar's Signature

DRIVE

State Registrar

within 24 hours aft

To the Funeral DI

completely filled in

			For State	State of Man				lental Hygi	ene	
			Registrar  1. Decedent's Name (First, Middle, La	ct)	Ce	rtificate of L	Jeam	Re 2. Date of Death	g. No.	3. Time of Death
4	Physici	an						Month	Day Year 2007	1:33 P M
	/Medic		William Roy Wa  4a. Facility Name (If not institution, giv	e Iters, Jr.	3	4b. City, Town, or	Location of Death	June	4c. County of Death	
	Examin	lei	Homewood Retiren	_			liamsport			ington
Text	Funeral		5. Social Security Number 6. S	ex 7. Age (	n yrs. last birthday,	<del>+</del>	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		nplace (State or Foreign intry)
34	Director		716-05-8216	XM 2□F	90 Yrs.	Montals Days		Nov. 20,	1916 Penn	sylvania
	w		Usual Residence of Decedent  10a. State 10b. County	10	0c. City, Town or L	ocation				10d. Inside City Limits
	f sho	0			W		L			1 ☐ Yes 2 💢 No
	the 28a-	Director	Maryland Washir  10e. Street and Number	igton	W	illiamspor 10f. Zip Code	-T	10	g. Citizen of What Cou	untry?
	3a ol		16505 Virginia A	venue Cotta	ae 211	217	795		USA	
	72 hours after death with the Maryland 'natural', or Items 23a or 23a-f show dical Examiner must be notified at	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?		Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Sp	ecify Yes or No-	14. Race - Ameri Black, White	
9	or Ite		1 X Never Married 2 Married	1 X Yes 2 ☐ No If Yes, Give	1942-	1 ☐ Yes 2 No	Specify:	rnoan, oto.,	Specify:	, 610.
21215-0036	ural",	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	1945	dontio Haval Oncor	ntino		W	hite
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Maryland	should be nd Mental marked o	오 B	William Roy Wa	alters, Sr.			Martha	Doroth	y Robinso	n
lar)	SPEE		19a. Informant's Name/Relationship (	Type. Print)	- 1				City or Town, State, Zi	
	1.4 2 블로		Lucinda Riley -							ginia 25403
Ore	0 0		20a. Method of Disposition  1 ★ Burial 2 □ Cremation 3 □	Inemoval nom State		osition (Name of ematory or other plac			20c. Location - City or T	
Baltimore,	t. Pa rtmen rtant: njury		4 □ Donation 5 □ Other (Special	1		n Mem. Par			Williamspo	rt, Maryland
Bal	permit. Page Department of Important: If any injury or once.		21. Signal e of Funeral S		4:		ococheagu	e St. Wi	lliamsport	21795 , Maryland
d			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the one cause on each line.	e death. Do not er	ter the mode of dying	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between
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Вох	eath certif attending for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf 1 ☐ Live birth 2 [	Fetal death 3	□Ectopic pregnancy			23d. Date of deliv	very Day Year
	ne dea the ar	/sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregnant at tin 9∐Unknown	ne of death 5	Other (specify)			Monar	Day Tour
P.0	hat the		Part II. Other significant conditions	contributing to death but r	not resulting in the u	underlying cause give	en in Part I.	23e. Did tob	acco use contribute to	the cause of death?
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<u> </u>	is is	O B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient	2 ER/Outpatie	nt 3 DOA Othe			nce 6 Other (Spec	eify)
0 0	ng Ph fter th neral	n: T	27. Manner of Death  1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Y	(ear) 28b. Time (	of 28c. Injury Work		28d. Describe how		
Sio	Attending r death. ector: After by the fune	atic	2 ☐ Accident investigation				Yes 2 □ No			
Division or Vital Records,	크를들트	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined			reet, factory, office		28f. Location (Str. City or Town,	eet and Number or Ru , State)	ral Route Number,
	Hospital 24 hours a Funeral stely filled		29a. Certifier 1 Certifying Pt	nysician: To the best of r	ny knowledge, dea	th occurred at the tin	ne, date and place,	and due to the ca	use(s) and manner as	stated.
	the Hin 24 the Figure 14 the F	Medical	one)	miner: On the basis of ex and manner state						
	To the To the comple	Σ	29b. Signature and title of certifier	. +++1		29c. License			od. Date signed (Month	
-	4P		Cypthia Ki	1111111-70	inas, mo	D4,	1451	7	une 25,2	001
	IVA		30. Name and address of person who cynthia Kuttne 31. Date filed (Month, Day, Year) JUN 26 2	completed cause of deat	h (Item 23a) (Type	Print)	sing Home	1650	5 Virginia	Avenue
	Sta	te	31. Date filed (Month, Day, Year)  JUN 26 2	32. gistrar's	Signature	7	Jw	Mamsp	ort, Mary	Jana 21195
	Registr	ar	JUN 262	007 Been	B. A.	out!				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. C. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** June 15, 6:00 P M 2007 Frances Mae Whitting /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince Georges Heartland Nursing Home Aldelphi, Maryland If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1□ M 21 F Yrs. 226-38-9996 Director 75 March 30, 1932 Virginia Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any filury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 X Yes 2 □ No Directo Maryland Prince Georges Suitland, 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6714 Marianne Drive, 20746 United States Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Completed by 3 ☐ Widowed 4 1 Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Custodian Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George A. Whitting Viola Taylor 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gloria Minor-Marlow / Daughter 6714 Marianne Drive, Suitland, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn Cemetery 6/22/07 Bowling Green, Virginia 21. Signatus Tuneral Service Lice 22. Name and Address of Facility Pope Funeral Homes, P.A. Larre 5538 Marlboro Pike, Forestville, MD 20747 23a. Part1. Enter the shock, or heart se, or complications that caused the death.
List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burlal-tra Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Be Completed by Physician/Medical as the IF FEMALE: If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed 2 N 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \text{ Notice Home} 5 \text{ Residence} 6 \text{ Other (Specify)} Hospital: 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3□ DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) filled in by the funeral 27. Manner Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Utural 5 ☐ Pending investigation s after death. 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide e Funeral 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. 29c. License number title of certifier 29d. Date\_signed (Month, Day, Year) 29b. Signature and 5 ess of person who completed cause of death (Item 23a) (Type, Print) 30. Name and add By State Registrar

		,	1 - For Stete Registrar	State of Maryland		tificate of L			giene Reg. No. 🛭 🗍	The last of the la	21061
ŗ	Physici /Medic		1. Decedent's Name (First, Middle, La.  Edith Viol	,				2. Date of Dec Month June 16	Day	Year	3. Time of Death  1:30 p M
	Examir		4a. Facility Name (If not institution, give Carroll Lutheran				Location of Death		4c. County	of Death	
L	Funeral Director		210-03-3703	7. Age (In yrs. la	as <i>t birthday)</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da Apr 29	y, Year) 1916	9. Birth Cou Mary	nplace (State or Foreign intry) yland
	Maryland a-f show ified at	ctor	Usual Residence of Decedent  10a. State 10b. County  Maryland Car	rroll 10c. City	, Town or Lo	cation	Westmins	ter			10d. Inside City Limits 1 X Yes 2 □ No
	ith with the 23a or 28 ust be not	ral Director	10e. Street and Number 205 St. Mark Way			10f. Zip Code	21158		10g. Citizen of	What Cou	intry?
920	be filed within 72 hours after death with the Maryland tital Hygiene. Ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1   Never Married 2   Married 3   Widowed 4   Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 □ Yes 2 M No If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 □ Yes 2 X No		ecify Yes or No- Rican, etc.)	14. Rad Blad Specif	ck, White	ican Indian, , etc. white
Maryland 21215-0036	within 72 ho iene. • than "natur the Medical I	Completed	15. Decedent's Et (Specify only highest grant properties) Elementary/Secondary (0-12)		16a. Deced (Give life.	dent's Usual Occupa kind of work done o DO NOT use retired Secretary	luring most of worki )	ing	16b. Kind of B		,
land 2	buld be filed Mental Hygid arked other atic event, th	To Be Co	17. Father's Name (First, Middle, Last,  Jacob Raymon			Jeon Gury	18. Mother's Name	(First, Middle, Ellen		ne)	
	d 2 shoth and the and the standard traum	-	19a. Informant's Name/Relationship ( Rhonda Zent Burto	on, niece	363 W	ng Address (Street a ling Foot	Drive, W				, ,
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other once.		20a. Method of Disposition  1 ☐ Burial 2 ☑ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specifications)  21. Signature of Funeral Service Licentifications	) Car	rroll	sition (Name of natory or other plac Crematory 2. Name and Addres	, 0,10,			field	d, MD
8	o a la Go	-	23a. Pant . Enter the disease, or com shock, or heart failure. List only	plications that caused the death one cause on each line.	9	1 Willis	Street, W	estmins	ster, MC		Approximate Interval Between
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a 'ol sequ		۹					Onset and Death
50,	rificate be executed g physician and as the burial-transit	I Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Due to lor as a corse u  c. Due to (or as a consequ	ence of:	Jewer	ria sev	હિ			5 yers
Box 68760,	death certificate t e attending physion of for use as the to	ian/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf pregnar  1 Live birth 2 Fetal 4 Pregnant at time of de	death 3	Ectopic pregnancy				ate of delive	very Day Year
P.O.	that the c ed by the detached	/ Physician/M	1 ☐ Yes 2 M No 9 ☐ Unknown	9□Unknown			en in Part I.	23e. Did to	obacco use con	tribute to	the cause of death?
cords	w requires been sign should be	leted by						1 🗆 \			obably 4 Unknown
or Vital Records,	an: The law tificate has b or, page 2 sl	e Completed	25. Was case referred to medical				26. Place of Death	1 Yes	rmed? 2 1 No	prior to co death? 1 ☐ Yes	ompletion of cause of
ž Ž	Physician: this certific	To Be	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ E	ER/Outpatier	t 3 DOA Othe				ner (Spec	ify)
ion	Attending P r death. ector: After t by the funera		27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	28b. Time of Injury	Work	/at k? Yes 2 ∐No	28d. Describe I	now injury occur	red	
Division	tal or Atte s after deg al Directo	Certification:	3 Suicide 6 Could not be determined	28e. Place of injury - At hor building, etc. (Specify,		eet, factory, office		28f. Location (5 City or Tov	Street and Numb vn, State)	ber or Rur	ral Route Number,
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page?	Medical	29a. Certifier 1 ☑ CertifyIng Pr (Check only one) 2 ☐ Medical Exam	nysician: To the best of my know miner: On the basis of examinati and manner stated.	vledge, deatl ion and/or in	vestigation, in my o	pinion, death occur	and due to the red at the time,	cause(s) and m date and place,	anner as and due	stated. to the cause(s)
	11/	Σ	29b. Signature end title of certifier	2, mo		29c. License	number 57174	-	29d. Date signe	id (Month)	, Day, Year)
	WZ		30. Name and address of person who	1 1		Print)	6 EL	Jerch.	. com is		71250
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signat		South !	10 , 000	0230	3,	<u>~D</u>	21707
			0011 1 0			120					

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** ALDERSTEIN GERTRUDE 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner CENTER HOSPITAL KANDAILS TO CON KENTHWEST If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) 1 □ M 2 🙀 F 05/22/1917 MD 212-18-3578 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2 No Director MD BALTIMORE BALTIMORE 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 7 POMONA NORTH APT. #5 U.S.A. 21208 Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married WHITE 1 ☐ Yes 2 No à Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOUSEWIFE OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be **ABRAHAM** KATZ ROSE SHAPIRO ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5411 SPRINGLAKE WAY - BALTIMORE, MD 21212 **NEIL ALPERSTEIN / SON** 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) BETH JACOB CONG. 07/06/2007 FINKSBURG, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Matt Cerin 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSCS Due to (or as a consequence of): URINAMI Sequentially list conditions, in the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2☐No 3☐ Probably 4☐Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an MiTABELLA 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 ☐ Inpatient 3□ DOA 2 ER/Outpatient Certification: To 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural

Examiner be executed burial-trar the

**Funeral** 

Director

show notified at

28a-f

7 is marked other than "natural", or Items 23a or traumatic event, the Medical Examiner must be 1

and Mental Hygiene.

partment of Health portant: If item 27 r injury or other tr

Department of Important: If any injury or

**Physician** /Medical

27

filed within 72 hours after

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Pages 1 and 2 should

3altimore, Maryland 21215-0036

P.O. Box 68760,

Division or Vital Records,

ed by the a signed by t director, this Hospital or Attending Pl 24 hours after death. Funeral Director: After the After 1

5 ☐ Pending investigation 2 Accident 3 ☐ Suicide 4 Homicide

6 Could not be determined

28a. Date of Injury (Month, Day Year)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier

29c. License number 1950) 29d. Date signed (Month, Day, Year)

within 24 hours a To the Funeral I

the

State Registrar 31. Date filed (Month, Day, Year)

ORIANDO

29a, Certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

B. CONANTA

32 Registrar's Signature

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For Amend 10b-d, perFH, g869, 7/9/07 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year 2007 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 8. Date of Birth Month, Day, Year) If Under 1 Year Months Days If Under 24 Hrs. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 🔀 F 215-80-662 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Reisterstown **Baltimore** other traumatic event, the Medical Examiner must be notified at 1 You 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō 'natural", or items 23a Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 日 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. þ Specify: 3 Widowed 4 Divorced BLAC Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than " Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. SUPERVISOR VRS BALTO CITY FIRE DEPT Important; If item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be Health and Mental ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Reral Route Number, City or Town, State, Zip Code) MUEASHA ABDULLAH DAUGHTER MD 21/36 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 9 1XBurial 2 ☐ Cremation 3 ☐Removal from State ZIONCEMETERY Injury o 4 ☐ Donation 5 ☐ Other (Specify) LANSDOWNE, MARVLAND Signature of Funeral Service Licensee TR. FUNERAL HOME N.H any BALTO. MD. 21217 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to ( r a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the death certificate be executed and burial-tran Due to (or as a con equence of): Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. Yes 2 the 9□Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an has page 2 autopsy certificate 1∐ Yes or Vital To the Hospital or Attending Physician; this certifical 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tyes 3 DOA ျှ 1 Inpatient 2 ER/Outpatient within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 5276C 1007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

200

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Buie Day Physician Month Year 290ry 2001 /Medical Facility Name (If not institution, give street and number, 4c. County of Death **Examiner** NIA If Under 24 Hrs. 8. Date of Birth (Morth, Day, Year) MAI/22/19 9. Birthplace (State or Foreign **Funeral** Months 1**X** M 2□F Hours Min. Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1XYes 2 No traumatic event, the Medical Examiner must be notified Director MARYLAND 10e. Street and Number og. Citizen of What Country? ō or items 23a Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. filed within 72 hours after ☐Yes 2 No Yes. Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 'natural', Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Int: If Item 27 Is marked other than GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 Is any Injury or other trainonce. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 ☐ Cremation ING HEM WOODLAWN 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory afrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pulseless Electrical Activity arrest **Physician** /Medical Due to (or as a consequence of): Examiner Sickle Cell 43 years sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Physician/Medical as attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 ☐ Other (specify) been signed by the a should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1XYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an cate has autopsy certificate 2 X No To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, p. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1XInpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural (Month, Day 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical

Records, or Vital

P.O.

State Registrar 29b. Signature and title of certifier

32. Registrar's Signature 31. Date filed (Month, Day, Year)

Danna M. Keloguin, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

Joanna M. Peloquin, M.D. 600 North Wolfe St. Baltimore, MD 21287

RES-000

29d. Date signed (Month, Day, Year)

July 5, 2007

Michael Blankensnip

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

INK UNK		State of Maryland / Department of Health and Mental Hy - For State Certificate of Death		eg. No.	1111	7 0107
Physician	1	Registrar  1. Decedent's Name (First, Middle,Last)	Date of Dea     Month	th		3. Time of Death
Medical Examine	er	Michael Blankenship	July 3, 20	07 ′		0958 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 733 S. Conkling Street Baltimore		4c. County	of Death	
Funeral	7	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs		rth (MM/DD/YYY	Y) 9. Birth	place (State or Maryland
Director		216-94-6535 1XM 2F 28 Yrs. Months Days Hours Min.	2/14	/1979	Cou	ntry)
any		Usual Residence of Decement  10a, State 10b, County 10c, City, Town or Location				10d. Inside City Limits
	١	MD Baltimore				1 X Yes 2 No
the Maryland or 28a-f show tiffed at once.	2	10e. Street and Number 10f. Zip Code	<u> </u>	I0g. Citizen of V		ry?
tifie I		3019 Pulaski Highway 21224		US <i>I</i>	Ą	
r death with or items 23	lera	11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married 2 Married Forces?  Armed Forces?  13. Was Decedent of Hispanic Origin? (Sp. 15 Yes, specify Cuban, Mexican, Puerto			ce - Americ ite, etc.	an Indian, Black,
ter dea		3 Widowed 4 Divorced If Yes Cive Year 1 Yes 2 X No specify:		Specify	Whi	te
ours aft	<u>6</u> -	15. Decedent's Education (Specify only highest grade completed)  16. Decedent's Usual Occupation (Give kind of w during most of working life. DO NOT use retired.)		16b. Kind of E	Business/In	dustry
6 n 72 h an "n ical E	Jiete	Elementary/Secondary (0-12) College (1-4 or 5+)	reu)	Const	truc	tion
5-0036 led within 72 hour Tygiene. other than "natu	Ę.	8th  17. Father's Name (First, Middle, Last)  18. Mother's Name	e (First, Middle,	Maiden Surnam	ne)	
MD 21215-0036 4.2 should be filed within 72 hours al th and Mental Hygiene. n. 27 is marked other than "natural numatic event, the Medical Examin	e l	Michael Blankenship, Sr. Kathle				
D 2121 (hould be fill hould be fill is marked attic event, TO Be	2	19a. Informant's Name/Relationship (Type, Print ) mother 19b. Mailing Address (Street and Number or F				
and 2 shoul lealth and N traumatic	-	Kathleen P. Sellars 3019 Pulaski Hwy.  20a. Method of Disposition 20b. Place of Disposition (Name of cemetery.	Balt:	20c. Location		
Baltimore, MD permit. Pages 1 and 2 st Department of Health an Important: If item 271 injury or other trauma		Burial 2 X Cremation 3 Removal from State crematory or other place)	9/2007	Balti	more	, MD
Iltim nit. Pa artmer ortani	t	4 Donation 5 Other Specify:	senh N	J Zanı	nino	Jr. FH
Dep Dem		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of				MD 21224
Physician M. ical		23a, Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of failure. List only one cause on each line.	or respiratory ar	rest, shock, or h	eart	Approximate Interval Between Onset and
Examiner	İ	Immediate Cause (Final disease or condition resulting in death)  a. Narcotic intoxication  Due to (or as a consequence of):				Death
		Sequentially list conditions,  b				
g		if any, leading to immediate  Due to (or as a consequence of):				
led nsit	i ai	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
60, ate be executed hysician and e burial - transit	<u>.</u>	UNPENDED AMENDED 280-F DOWNE 0860 7/27/07 TT		<del></del>		
60, ate be hysicia e buri	Med	##24,27,2041, DETPL, 2009, 7/27/07 II  IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date	of delivery	
687 certific ding p	an/	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnate time of death 5 Other (Specific)	ancy	Month	D	ay Year
Box 687/e e death certifics the attending pled for use as the	Physician/N	1 Yes 2 No 9 Unknown 9 Unknown				
that the death certifical that the death certifical ned by the attending phe detached for use as the by the Division of the bound of th	2	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				he cause of death?
Division of Vital Records, P.O. rate or Attending Physician: The law requires that the and predeath.  In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	Be		1 Ye			ably 4 Unknown
ord aw req bas bee	Completed		auto			ompletion of cause of
Rec The ficate	5	25. Was case referred to medical 26. Place of Death (Check	1 Yes	2 No	1 Ye	s 2 No
/ital	<u>8</u>	examiner? Hospital: Inserting 2 FR/Outpetient 3 DOA Other, Nursein	ng Home 5	Residence 6	<b>✓</b> Other:	Scene
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Division of Vital Records, F spital or Attending Physician: The law requires torst and read by the law requires heral Director: After this certificate has been sign filled in by the funeral director, page 2 should be contributed.	┋	3 Suicide 6 X Could not be determined (Specify) house	or Town,	State)		al Route Number, City
lospits 4 hours iunera		4 Homicide 1000SE				altimore, MD
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitional Contification. To Be Completed by Directorian Madical Expedition 1	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	at the time, date	e and place, and	due to the	e cause(s)
F 3 F 8	ğ	29b. Signature and title of certifier 29c. License number			,	nth, Day, Year)
- W. W		M. H to O.C.M.E.		July 4, 20	JU /	
1 0 land		30. Name and address of person who completed cause of death (Item 23a)  Margarita Korall MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD	21201			
Stat	te	31. Date filed (Month, Day, Year) 32. Segistrar's Signature				
Registra	44	111 0 9 2007   House J. Marie				

Please Type of Print in Black Indelible Ink. Ensure All Copies Are Legible. 07-05134 State of Maryland / Department of Health and Mental Hygiene Charles Leslie VanCamp Certificate of Death 2007- 21871 Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day July 5, 2007 0555 hrs **Medical Examiner** Charles Leslie VanCamp 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Crofton Anne Arundel 1701 Gaffney Court If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) Funeral Months Davs Hours Country) Director 374-64-4160 Mar. 15, 1956 51 1X M 2 F WV Yrs Usual Residence of Deceden 10c. City, Town or Location any 10a. State 10d, Inside City Limits or 28a-f show 1X Yes 2 No MD. Anne Arundel Crofton or items 23a or 28a-f shormust be notified at once. hours after death with the Maryland Director 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 1701 Gaffney Court 21114 TISA Funeral 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 1 Never Married 2 X Married Armed Forces? if Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. Yes 2 X No haltimore, MD 21215-0036
mit. Pages I and 2 should be filed within 72 hours after d
agreement of Health and Mental Hygiene,
portant: If item 27 is marked other than "natural", or
ary or other traumatic asset. Yes 2 X No specify: White 3 Widowed 4 Give Yea Divorced Specify: \$ 16a. Decedent's Usual Dccupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Postal Management <u>Government</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bernard Wayne VanCamp Be Norma Jean Binnie 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Zimmerman/Wife 1701 Gaffney Court Crofton, Md. 21114 20b. Place of Disposition (Name of cemetery, 20a, Method of Disposition Date 20c. Location - City or Town, State Baltimore, 1 Burial 2 Cremation 3 Removal from State crematory or other place) Oakland Hills Cemetery 7-13-07 Novi, MI 4 Donation 5 Other Specify: permit.
Departm
Importa injury 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Charles L. Stevens F.H. Inc. Dorota W. Marshall per dvr 1501 Fast Fort Ave. Balto. Md. 21230

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line. Between Onset and /Medica Death a Stab Wound of Chest Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and transi The law requires that the death certificate be executed Physician/Medical 5-22 per fh g870 8-28-07 vt X AMENDED UNPENDED signed by the attending physician be detached for use as the burial Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Dav Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknowr Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>≙</u> Yes 2 ✔ No 3 Probably 4 Unknown Completed After this certificate has been funeral director, page 2 should 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be examiner? Other<sub>4</sub> Hospital: Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ✔ Other: Scene ဥ 1 V Yes 28a. Date of Injury Month, Day, Yaar FOUND: 27. Manner of Death 28b. Time of Injury 28c. Injury at Work's 28d. Describe how injury occurred Medical Certification: Subject stabbed self **FOUND** 1 Natural 1 Yes 2 ✔ No Pendina Jul 5, 2007 0530 hrs 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 🗸 Suicide Could not be or Town, State) 1701 Gaffney Court, Crofton, MD determined (Specify) Single Family 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, I

30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner

8

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

and manner stated

32

111 Penn Street, Baltimore, MD 21201

29c. License numbe

O.C.M.E.

29d. Date signed (Month, Day, Year)

July 5, 2007

Registrar

Certificate of Death

Reg. No.-

Day

6:00 a.m.M

Howard

U.S.Á.

food service

Birthplace (State or Foreign Country)
 New York

White

Approximate Interval Between Onset and Death

Day

worlt

Year

5005

10d. Inside City Limits

1 ☐ Yes 2 🙀 No

2. Date of Death

Month

2. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

2007 9

For State Registra

1. Decedent's Name (First, Middle, Last)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TIEM/8 perFH & 7/10/07 WS
State of Maryland / Department of Health and Mental Hygiene State Registrar Amend #8, perFH,g869, 7/11/07 TT Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** JULY 2007 10 12:50 PM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death CECIL VA MARYLAND HEALTH CARE SYSTEM PERRY POINT If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 14 **Funeral** Days Months Min. 2∏ F Hours 78-245 648 Director BURWELL; KARLTON Usual Residence of Decedent the Maryland 10a. State 10h. County 10c. City, Town or Legation 10d. Inside City Limits 28a-f show notified at Director ec 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country; with 1 5 æ Ward 14 12. Was Decedent Ever in U.S. Armed Forces? Funeral 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Examiner Black, White, etc 1 and 2 should be filed within 72 hours after 1 ☑ Never Married 2 ☐ Married 1 Nes 2 □ If Yes, Give Year or Dates: 2 □ No 0 Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. þ Specify: 3 Widowed 4 Divorced "natural", Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry PHYSICIAN: Disab Elementary/Secondary (0-12) College (1-4or 5+) WIT IC vives 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Durwell ank ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KNOWN TO andra -Suller 8500 Richard, VA. permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr once. Spring HOLLONDY. Williams 2322 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Methød of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 

Other (Specify) forest vet nes MIKIS, MD. 21. Signature of Fineral Service Ucense 22. Name and Address of Facility FredHILTON Pass NAME Home Back, and, 21229 MAN Pimardi 23a. Part Fen I he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or Lart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate ar se (Final disease or condition resulting in death) **Physician** METASTATIC CANCER OF HEAD AND CHEST OF UNKNOWN /Medical Due to (or as a consequence of): Examiner MONTHS PRIMARY if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examir Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical attending p IF FEMALE: . If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CEREBROVASCULAR ACCIDENT 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 funeral director. 25. Was case referred to medical examiner? 26. Place of Death Check onl one ? X 2∐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Pruneral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 1 🕰 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 6 grown D15628 JULY 6, 2007 wur) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CAROLINA CUSTODIO, VA MARYLAND HEALTH CARE SYSTEM, PERRY POINT, MD 21902 M.D 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 200 /Medical 4a. Facility Name (If not institution, give street and number, 4c. County of Death **Examiner** N/A 9. Birthplace (State or Foreign Social Security Number 1 M 2 □ F Hours мопін, Day, Ye -4-1951 MARY LAND Yrs 212-60-9332 55 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 X Yes 2 □ No Director MD. N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 501 E. PRESTON ST. APT 727 21202 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No Specify: BLACK Specify: 2 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) -10-College (1-4or 5+) DISABILED DISABILITY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JAMES E. BURNETTE RITA PONGEE ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BERNARD BURNETTE (BROTHER) 1908 W. FRNKLIN ST. BALTIMORE, MARYLAND 21223 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 ☐ Removal from State 4 □ Donation /5 □ Other (Specify) METRO CREMATORY 7-3-2007 BALTIMORE, MARYLAND ${ m HIBNER}^{22}$ . Name and Address of Facility 21. Signature of Juneral Service Mceuse JONATHAN REDD FUNERAL SERVICE . BALTIMORE, MARYLAND 21217 MONROE N. 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Esqueritally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Month Day 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably Completed Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2/ 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 1 Appatient 3 DOA 2 ☐ ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending 2 Accident investigation 1 ☐ Yes 2∏No 6 Could not be determined

certificate be executed Box 68760, Ö σ. Records, or Vital

and as the burial-trag attending physician Į. signed by the a d be detached f page 2 s certificate After t Division or Attending death. the

**Funeral** 

Director

with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician

/Medical

Examiner

Examine

Maryland 21215-0036

Baltimore,

Funeral Director: To the Hospital within 24 hours To the

Be

မ

Certification:

Medical

3 Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

Registrar

JUL 0 9 2007

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 00

WOL 32. egistrar's Signature

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

07-05166

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Clyde Hussie Carroll, Jr State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day July 6, 2007 Hussie 0655 hrs Medical Examiner Clyde Carroll Jr. 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Sykesville 7007 Beachmont Drive 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY 5. Social Security Number 6. Sex Funeral Months Days Hours Country) NC Director 240-72-0401 61 June 16 1945 1 X M 2 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County MD Carrol1 Sykesville 1 Yes 2 No or 28a-f show items 23a or 28a-f shoust be notified at once. Baltimore, MD 21215-UU50
permit Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f shi
injury or other traumaric event, the Medical Examiner must be notified at one Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7007 Beachmont Drive 21784 USA Funeral 13. Was Decedent of Hispanic Ongin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 X Married Yes 2 X No Divorced If Yes, Give Yea Specify: White 3 Widowed 1 Yes 2 X No specify: 4 ੬ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) accounting clerk accounting +2 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clyde H. Carroll Sr. Addie Elna Messick ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jane Carroll (spouse) 7007 Beachmont Dr., Sykesville, MD 21784 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) Burial 2 X Cremation 3 Removal from State All County Cremation 7-10-07 Sykesville, MD Donation 5 Other Specify: 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service License Baige Haight & Box 195 Sykesville, MD 21784 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line /Medical a. Cirrhosis of the Liver Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) b. Alcohol Abuse Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause Exami (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and Physician/Medical the attending physician hed for use as the burial -UNPENDED AMENDED Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Year Fetal death Month Dav 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? icate has been signed I page 2 should be deta ð 1 Yes 2 ✔ No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? certificate ✓ Yes 2 1 🗸 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Other 4 Hospital: Residence 6 V Other: Scene Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 this 1 V Yes After 27. Manner of Death 28a. Date of Injury (Month, Day, Yaar) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 V Natural n 24 hours after death
e Funeral Director: A
letely filled in by the fu Yes 2 No Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical within 2. one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner state 29c. License number 29b. Signaturi and title 29d. Date signed (Month, Day, Year) O.C.M.E. July 6, 2007 30. Name and address of person who con pleted cause of death (Item 23a) Assistant-Medical Examiner 111 Penn Street, Baltimore, MD 21201 Susan Hogan MD. 31. Date filed (Month, Day, Year, 32. Registrar's Signature State

Registra

07-05178 Zohaib Choudhry

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2007 2107 Certificate of Death 1- For State Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ July 6, 2007 Year 0925 hrs Medical Examiner Choudhry Zohaib 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore** University Hospital NA If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Foreign Min. Months Days Hours 9-10-1985 Country) Pakistar Director 123-86-4317 21 1 XM 2 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State Yes 2 X No or 28a-f show s 23a or 28a-f shov e notified at once. Md. Wicomico Parsonburg Director 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21849 **TISA** 32969 Old Ocean City Road 14 Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 11. Marital Status 12 Was Decedent Ever in U.S. or items pe White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces' 2 X Married must 1 1 Never Married 2X No Vec Iltimore, MD 21215-0036

rine. Pages I and 2 should be fifted within 72 hours after d
remen of Health and Mental Hygiene.

retant: If item 27 is marked other than "natural", or
y or other traumatic event. In Marian. Yes 2 X No specify: Pakistani f Yes. Give Year Widowed þ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) Education . Student 12th grade 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Choudhry Akhtar Nasreen Be Younis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) ۵ Baltimore, MD 32969 Old Ocean City Road, Parsonburg, Md. 21849 Sana Choudhry 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition XBurial 2 Cremation 3 Removal from State crematory or other place) Department or Important: I Family Cemetery Punjab, Pakistan 7-11-07 Other Specify 22 Name and Address of Facility Signature of Funeral Service Licenses March F.H. East 1101 E. North Ave., Baltimore, 21202 Approximate Interval Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line Death /Medical a. Multiple Injuries Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury macinitiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical AMENDED UNPENDED attending physician or use as the burial The law requires that the death certificate be Box 68760 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy Day 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Month Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown ŧ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 1 Yes 2 V No 3 Probably 4 Unknown δ Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of has performed' death? 2 No certificate h ector, page ✔ Yes 2 ✓ Yes 26.Place of Death (Check only one) 25. Was case referred to medical To the Hospital or Attending Physician: Division of Vital Be Other; Hospital: 1 Inpatient Nursing Home 5 Residence 6 ER/Outpatient 3 2 this 1 🗸 Yes No 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury Jul 5, 2007 28b. Time of Injury 27 Manner of Death After Motorcyclist in motor vehicle accident Certification: 1500 hrs 1 Natural 1 Yes 2 ✔ No 5 Pending Director: death. 2 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. hours after 3 Could not be or Town, State) Rt. 50 / By-pass , Salisbury , MD Suicide To the Funeral D determined (Specify) Major Road / Highway 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 1 72 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29c. License number 29d. Date signed (Month, Day, Year) ignature and title of certifie 29b July 7, 2007 O.C.M.E. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Laron Locke MD. Assistant Medical Examiner Registrar's Signature 31. Date filed (Month, Day, Year) State

**ORIGINAL** 

Registrar

DHMH 17 Rev 1/2001

State

Registrar

MANISHA

31. Date filed (Month, Day, Year)

BAHL, MD

2007

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. Registrar's Signature

MARYLAND 21239

07-05107 Pedro Colon

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		Dundalk Avenue @ D		A (10	iethelous)	If Under 1 Year	If Under 24Hrs.	8. Date of Birth(M	M/DD/YYYY) 9. I	Birthplace (State or
Funeral	5.	Social Security Number	6. Sex	Age (In yrs. last b	oirtnday)	Months Days			I ⊢or	eign Country) PENNA.
Director	1	118-86-1827	1 X M 2 F	3	Yrs.			MAY IL	1972	LINAM
		sual Residence of Decedent			1					10d. Inside City Limits
any	10	a. State 10b. County	ê.	10c. City, Tov	wn or Locatio	on .				1 X Yes 2 No
	_   _	M GRANUAN	'/A	BAL	Tim	ORF 10f. Zip Code		111.61	Citizen of What C	
and 2 should be filed within 72 hours after death with the Maryland lealth and Mental Hygicine.  Item 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once traumatic event, the Medical Examiner must be notified at once traumatic event, the Medical Examiner must be notified.	2 27	e. Street and Number				10f. Zip Code				ountry :
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Ment Mark mark		9a. Informant's Name/Relation			19b. Mailin	g Address (Stre	et and Number or	Rural Route Number	r, City or Town, a	state, zip code)
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permit. Page Department of Important: injury or oth	_	4 Donation 5 Other 21. Signature of Funeral Service	Specify:	0///	22,	Name and Addres	ss of Facility	ED INP.	GUNED D	Approximate Intel
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sician dedical	1	failure. List only one caus	se on each line.					114		Death
kaminer		Immediate Cause (Final disea		consequence of):						
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re des	Physicial	Part II. Other significant cor			sulting in the	e underlying caus	e given in Part I.			oute to the cause of death
To the Hospital or Attending Physician: The law requires that the death certificate by within 24 hours after death.  To the Fineral Director: After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the but	by F	rait ii. Other significant con	23/11/20/19		•			1 Yes	2 🗸 No 3	Probably 4 Unkno
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Hospital or Attend 24 hours after death Funeral Director: tely filled in by the		4 Homicide 29a. Certifier 1 Certifyir					e, date and place,	and due to the caus	e(s) and manner	as stated.
To the Hos within 24 h To the Fun completely	ical	(Check only one) 2 Medical	Examiner: On the basis	of examination a	and/or invest	igation, in my opi	nion, death occurre	ed at the time, date	and proven	
To the within 2 To the complet	Medical	29b. Signature and title of ce	and manner	stated		29c. Lic	ense number		29d. Date sign	ed (Month, Day, real)
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1	1	30. Name and address of pe	erson who completed car	use of death (Iten	n 23a) 111 Den	n Street Bal	timore, MD 21	1201		
1		Carol Allan, MD	Assistant Medica	J. P. Carlot						
	tate		/	Redistrar's Signat	La .	1.0.				ME -
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 9 per 1h 8869 7-9-07 vt. State of Maryland? Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 200 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number, Examiner SECOURS BALLI MORE If Under 1 Year | If Under 24 Hrs. 6. Sex M 2 □ F Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours MD. JULY 4, 67 1940 Director 211-36-8424 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State r 28a-f show notified at 10b. County 1 ∏Yes 2 No MT) Director BALTIMORE 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be re-2723 PARKWOOD AVENUE 21217 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Sytes 2 □ No If Yes, Give Year or Dates: 1958–63 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: BLACK Specify: 3 ☐ Widowed 4 A Divorced Completed by 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) PEPSI COLA CO. 12 DRIVER permit. Pages 1 and 2 should be filed a Department of Health and Mental Hygis Important: If item 27 Is marked other 1 any injury or other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဂ္ WILLIAM CARROLL DOWERY, SR. LOUISE THOMAS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) WILLIAM C. DOWERY, III 2723 PARKWOOD AVE., BALTO., MD 21217 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State CROWNSVILLE VET. CEM 07/13/07 CROWNSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC 1701 LAURENS ST., BALTO., MD 21217 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition

ESOPHAGEL

Cancer Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as consequence of): Examiner 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine death certificate be executed attending physician and for use as the burial-transit P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 □Ectopic pregnancy Month Dav Year in the past 12 months? 5 ☐ Other (specify) ☐Yes 2☐No detached the 9□Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed I Division or Vital Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy certificate 2 **1**No 1□ Yes Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 10 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA ပ this filled in by the funeral 27. Mann Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred e Hospital or Attending Pl 24 hours after death. e Funeral Director: After the 28a. Date of Injury Certification: After (Month, Day Year) Injury 1 \_ Natural 5 ☐ Pending investigation 1 □ Yes 2 □ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral 1 Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who exmpleted death (Item 23a) (Type, Print) BON SECOUR 0 Year) 31. Date filed (Month, Day, State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene

1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** DIELISA JOHN 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 24 Hrs. 115 Date of B Birthplace (State or Foreign
Country) 5. Social Security Number 6. Sex **Funeral** 1 MM 2□F Months Days 152-34 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 ie marked other then "natural" ~~ any injury or other traumatic event. 10c. City, Town or Location 10d. tnside City Limits 10b County 10a, State 1 ☐ Yes 2 ☐ No by Funeral Director heuser 10e. Street and Number Of. Zip Code 10g. Citizen of What Country? RRIBOX224-G 26726 115A 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Ves 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 20 Married 1 ☐ Yes 2 ☑ No White Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use-retired). 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Be 19b. Mailing Address (Street and Number or Rural Route Number, 26726 20b. Place of Disposition (Name or cemptary, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenseg neralSucs Vauen ellattiPine Baltimore, Md 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) RESPIRATORY Physician FAILURE 6 DAYS /Medical Due to (or as a consequence of): Examiner 3 MONTHS ABSCESS HEPATIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) attending physicien and for use as the burial-transit Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Day Month 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 (Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐Unknown should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has t lirector, page 2 s P No Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funerel Director: After this certifica completely filled in by the funeral director, p To Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 1 ☐ Yes 2 ☑ 1√0 2 ER/Outpatient 3□ DOA 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medicai 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier July 5. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CRISTINE BERRY BALTIMARE, MARYLAND 21287 600 NORTH WOLFE STREET 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

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			1. Decedent's Name (First, Middle, Last)						2.	Date of Dea Month		Year	3. Time of Death
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			University of Maryla	nd Medi	ial Ce	Hen	Balti	more				Saltin	nore City
	Funeral		5. Social Security Number 6. Sex	7. Age	(In yrs. last		If Under 1 Year Months Days	If Under I	24 Hrs. 8. Min.	Date of Birth (Month, Day une 27	Year)	9. Birth	hplace (State or Foreign® untry)
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	and *	}	Usual Residence of Decedent  10a. State 10b. County		10c. City, To	own or Loc	ation						10d. Inside City Limits
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	the tage	Director	10e. Street and Number				10f. Zip Code			1	10g. Citize	n of What Co	untry?
	within 72 hours after death with the Maryland one. Then "naturel", or items 23a or 28a-f show Te M. dical Examinan rust be notified at		3611 Fairhaven A	venue Apt	. 2			1226			U	J.S.A.	
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21215-0036	rel', c	b	3 Widowed 4 Divorced	If Yes, Give Year or Dates:			Yes 21X No	Specify:			5,	pecity: Wil	
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CA			17. Father's Name (First, Middle, Last)	2 years		Dusi	iless riai		er's Name (Fi	ret Middle			aper
Maryland	d tal	Be		bert Dav	is				oris N			arrame)	
Ž	should be and Mental is marked o	2	19a. Informant's Name/Relationship (Type			19h Mailin	Address (Stree					Town State 7	īn Code)
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ā,	is 1 and 2 should of Health and Men item 27 is marke other treumatic	1 3	20a. Method of Disposition		20b. Place	of Dispos	sition (Name of		Date			tion - City or	
Baltimore,	Pages nent of I int: If its iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re '4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	_		atory`or other pla Cremator		7/2/20	007	Ralti	more.	Maryland
Ħ		l i	21. Signature of Fuperal Service License	As A No	Day v	the state of the s	Name and Addr						e, P.A.
Ba	permit. Departr Importa eny inji		1 Hono U	ldrid	ge	40	001 Ritcl	hie Hi	ghway	Balt	imore	Mary	land 21225
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	Physician "	ξ Ţ	Immediate Cause (Final	o cause on each lim	-	Con	Seps	ie					Onset and Death  2 weeks
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Д	that the ed by detail		Part II. Other significant conditions con	tributing to death bu	t not resultin	g in the un	derlying cause gr	ven in Part I.		23e. Did to	bacco use	e contribute to	the cause of death?
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Vital		ŭ	25. Was case referred to medical					26 Place	of Death (C		22 No		2 140
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Division	of or Attend after death Director: / d in by the f	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju- building, etc	ry - At home . (Specify)	, farm, stre	et, factory, office		28f.	Location (S City or Tow		Number or Au	ural Route Number,
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	To the Hospitel or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune.	ical	29a. Certifier 1 Certifying Phys 2 Medical Examin	er: On the basis of	examination								
	To the within 2 To the Complet	Medical	29b. Signature and title of certifier	and manner sta	ted.		29c. Licen	se number			29d. Date	signed (Mont	h, Day, Year)
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**ORIGINAL** 

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) <sup>Day</sup> 2007 **Physician** Elias Dorothy Evelyn 1:00 pm July 5, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Kline Hospice House Mount Airy Frederick | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. | 09/12/1922 Birthplace (State or Foreign Country)
 MI 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 84 381-26-4540 1 ☐ M 21X F Yrs Director Usual Residence of Decedent with the Maryland 10b. County Genesee permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if itam 27 is marked other than "natural; or itama 23a or 28a-f show sny injury or other traumatic avant, the Medical Examinat must be notified at once. 10c. City, Town or Location 10d. Inside City Limits Clio 1 Yes 2 No **Funeral Director** 10f. Zip Code 48420 10g. Citizen of What Country? 10e. Street and Number 2372 Bingham Road USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 25 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 Yes 2 XNo Specify. ģ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Walter Leonard Crowder Alice Alberts Hazel 19a. Informant's Name/Relationship (Type, Print)
Gwen Barnette/ Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6356 Kings Court, Flushing, MI 48433 20b. Place of Disposition (Name of 07/09/2007 20c. Location - City or Town, State 20a. Method of Disposition Flint Memorial Park 1 Burial 2 Cremation 3 Removal from State Flint, MI 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses <sup>22</sup>. Name and Address of Facility
Charles L. Stevens Funeral Home Inc.
1501 East Fort Avenue, Baltimore, MD 21230 - Marcha 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** C'erebrovasculor Accident /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualto (or as a consequence of) Examine physicien and s the burial-transit the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical use as 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy 2 Fetal death Month Dav Yea 4☐Pregnant at time of death 5 Other (specify) Records. P.O. 1 ☐ Yes 2 🛣 No been signed by the should be detached 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ tibrilla tron 1 Yes 2 No 3 Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cete has page 2 s autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, t 25. Was case referred to medical examiner? 26. Place of Death [Check only one] Hospital: Other: 4 Nursing Home 5 Residence 6 SOther (Specify) Hospice 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 T Homicide 29a. Certifier 1 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and glace, and due to the cause s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number UCU - MD D0058726 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Myersville 3000-D Ventrie Ct. wette Warren 31. Date filed (Month, Day, Year) -32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician 10.45 PM 12 Hilda McDaniel 0 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Carroll Hospital Center Westminster Carroll If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 1□M 2□F Months Days Hours Min. 216-03-5599 Director 1911 MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ ... any injury or other traumatic even. 10d. Inside City Limits 10a. State 10b. County 10c, City, Town or Location Sykesville MDCarrol1 1 ☐ Yes 2 ☑ No Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21784 2810 Kaywood Place USA 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify: white þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) telephone operator communications 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Clara Barth Walter D. McDaniel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) P.O. Box 418, Trappe, MD 21673 Pat Jones (niece) 20b. Place of Disposition (Name of cemetery, crematory or other place) Springfield Cemetery 20a. Method of Disposition 20c Location - City or Town State 1 → Burial 2 □ Cremation 3 □ Removal from State Sykesville, MD 7-9-07 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee Daige Haight Aerbert P.O. Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician monan disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner physician and s the burial-trans resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2♥ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed 2 **X**No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Yes 2√No 1 Inpatient မ this 28a. Date of Injury 27. Manner of Death 28b Time of 28d. Describe how injury occurred Injury at Work? Certification: (Month, Day 5 ☐ Pending investigation 1**√**Matural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, within 24 hours after death To the Funeral Director: completely filled in by the

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State Registrar

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) I ARIO MA I MUUI) 19 19 19 19 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a. Certifier

(Check only one)



and manner stated

Registrar's Signature

**ORIGINAL** 

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

Westminster MD2115

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07-05037 State of Maryland / Department of Health and Mental Hygiene Deysaud P. Fisher 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 3. Time of Death .Decedent's Name (First, Middle,Last) Physician/ Month Day July 1, 2007 2330 hrs Medical Examiner saud 4c. County of Death 4b, City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number Salisbury Wicomico Peninsula Regional Medical Center If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Hours Min Director 693-01595 Country) \ 1 M 2 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 No 23a or 28a-f show notified at once. alisbur Director 10g. Citizen of What Country? 10e. Street and Number USA 409 theene. 21804 Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 14. Race - American Indian, Black, 11. Marital Status 12, Was Decedent Ever in U.S must be Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married Yes <u>.</u> Black Yes 2 No specify: Pages 1 and 2 should be filed within 72 hours after If Yes, Give Year at of Health and Mental Hygiene.

it: If item 27 is marked other than "natural", other traumatic event, the Medical Examiner. Widowed 4 Divorced ģ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) 21215-0036 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Snanita Hisher Be herraud 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Gede 19a, Informant's Name/Relationship (Type, Print) Shanitaltisher heene 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Burial 2 Cremation 3 Norfolk, VA Removal from State 9107 Important: injury or otl Vari Donation 5 Other Specify dame res of Coulty ex Signature of Funeral Service Licensee Pine Battonor Md 21224 Baltimore Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line /Medical Death Asthma Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical XUNPENDED AMENDED 7, perME, g870, 8/8/07 TT Box 68760 23d. Date of delivery If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify, 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? The law requires that the contributing to death but not resulting in the underlying cause given in Part I. o á 1 Yes 2 V No 3 Probably 4 Unknown Completed Records, 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy has 2 sl performed? ✓ Yes 2 1 🗸 Yes 2 No certificate 26.Place of Death (Check only one) the Hospital or Attending Physician: 25. Was case referred to medical Be of Vital Other: examiner? Hospital: 1 Nursing Home 5 Inpatient 2 V ER/Outpatient 3 DOA this ۲ 1 🗸 Yes No After t 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: X Natural Yes 2 No Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) determined To the Funeral Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Donna no incut in in O.C.M.E. July 2, 2007 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Donna M. Vincenti, MD Assistant Medical Examiner 32 Registrar's Signature 315000 State Registra

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July <sup>Day</sup> 2007 **Physician** 9:12 AM 3, John Raymond Frank /Medical 4a. Facility Name (If not institution, give street and number) 2502 Edgewood Ave. 4b. City, Town, or Location of Death 4c. County of Death Examiner Parkville Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth Month, Day, Year April 28, 1924 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1**X**M 2□ F Months 217-20-1792 83 yrs. Director Baltimore, MD Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Merital Examiner must be notified at Baltimore Parkville MD 1 ☐Yes 2 No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 2502 EDgewood Ave. USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces?

1 Yes 2 No Navy
If Yes, Give Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specif White þ 3 Widowed 4 □ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Corner Stable Manager Lounge N/A 12 Father's Name (First, Middle, Last)
Theodore S. Frank 18. Mother's Name (First, Middle, Maiden Surname)
Carrie V. Shanklin Be h and Mental H ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 18 Briarcliffe Dr. Scotch Plains, NJ 07076 of Health Sharon MacHrone-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other programmer)
Dulaney Valley
Memorial Garde 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any injury or ot
once. 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 7/7/2007 Timonium, MD Gardens 21. Signature of Funer di Critica Lices 22. Name and Address of Full Peral Chapel & Cremation Services Parkville 8800 Harford Rd. Parkville, MD 21234 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Bucide Gunshot disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_ in the past 12 months? 1☐ Yes 2☐ No Month Day 4□Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has be inector, page 2 s autopsy performed? 1☐ Yes 2 X No 1 ☐ Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 □ No Be 26. Place of Death (Check only one) Hospital: Other: Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 🗆 Nursing Home this 5 Residence 6 □Other (Specify) 27, Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation Injury Selfinflixed Gun Shot Wound July 3, Zoo7 G:12 AM M 10 28e. Place of injury- At home, farm, street, factory, office building, etc. (Specify) 1 ☐ Yes 2 No Director: 2 Accident 3 Suicide 4 ☐ Homicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number City or Town, State) 2502 Eda 2000 City or Town, State) 2502 Edg & well Aug Beltimosp M) 21234 (PARKU! 1) e) within 24 hours aff
To the Funeral D
completely filled in Home To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day,

Year)

32. Re

istrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 6:02 AM Garrett L. Freeland 2007 Jule /Medical County of Death Harford 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Upper Chesapeake Bel Air If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Davs | Hours | Min. | (Month, Day, Year) 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex **Funeral** Days 1 MM 2 TF 484-05-9816 9 1 Yrs. Oct. 15, 1915 | Iowa Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f show Examiner must be notified at MD Harford Bel Air 1 ☐ Yes 2 No Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 1435 Valbrook Ct. South 21015 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: Navy 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: White Specify: <u>ک</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)

Loan Insurer General Accept Corp. Elementary/Secondary (0-12) College (1-4or 5+) 12 injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname)
Beulah Crouch 17. Father's Name (First, Middle, Last) Be s 1 and 2 should be fil f Health and Mental H tem 27 is marked ott Ansel Freeland 19a. Informant's Name/Relationship (*Type. Print*)
Marguerite Freeland/Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1435 Valbrook Ct. South Bel Air, MD 21015 permit. Pages 1 an Department of Heal Important: If Item 2 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ★ Cremation 3 ☐ Removal from State Forest Hill, MD Evans Funeral Chapel 7/7/2007 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Furtheral Chapel & Cremation Services Parkville 8800 Harford Rd. Parkville, MD 21234 archae 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 3-{a **Physician** rent 20010 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine that the death certificate be executed Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) Ö 9 Unknown 9 Unknown þ ئە Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Ś 1 | Yes 2 | No 3 | Probably 4 | Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 2 PIN Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Thepatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 🗷 No 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide or la To the Hospital or within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 6,2007 DO053568 XI 500 uper Chesapeake 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

1 eff rees

31. Date filed (Month, Day, Year)

Registrar

MOZO

82 Registrar's Signature

Caila Isabel Teresa	1	For State	ate o	f Marylaı	nd / E	Departmer <i>Certificat</i>		Health an	d Men	ntal Hy		- N-	20	Ö7	2133
Physician/		egistrar I. Decedent's Name (First, Midd	le,Last)							2	2. Date of De			3. Ti	ime of Death
Medical Examine		Caila Isabel T	eres	sa Finn	ien						Month July 5, 26	007 Day	Year	2	034 hrs
•	4	a. Facility Name (if not institution Greenspring & Tufton		street and num	nber)		4	b. City, Town, or Reisterstov		of Death			c. County of De Baltimore C		
Funeral		. Social Security Number	6. Sex	1	7. Age (Ir	n yrs. last birthd	ay)	If Under 1 Yea		er 24Hrs.	8. Date of E	Birth (MM.	/DD/YYYY) 9.		ce (State or
Director	L	213-31-6018	1N	и 2 <u>XX</u> F	0	16	Yrs.	Months Day	rs Hour	s Min.	Oct.	4,	L990 For	reign Country)	Maryland
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r death with the Maryland or items 23a or 28a-f show must be notified at once. Funeral Director	5		arried	Armed For		-		es, specify Cuba				.0-	White, etc		ndian, bidok,
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5-0036 ed within 72 hour lygiene. the Medical Exar Completed	2	Elementary/Secondary (0-12)		College (1-	4 or 5+)		C+1	udent					orth Ca igh Sch		11
sd with squeece yagene other the Me	<u> </u>	17. Father's Name (First, Middle	, Last)				טני	daent			First, Middle	, Maider	Surname)	1001	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than event, the Medical	3	William Leo Fi							•		uise S				
should and Me is ma atic ex	2 [	19a. Informant's Name/Relations				1.1		Address (Stre							
and 2 sho ealth and lem 27 is traumati	-	William L. Fin	nen.	, 111 (	rati			ition (Name of ce		Τ -	Date		Location - City		
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygie with "natural", or items 23a or 28a-f she important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director		1 Burial 2 Cremation 4 Donation 5 Other S	oeeifv:		m State		or oth	er place) eatory		July 2007		Ca	tonsvil	le,	Maryland
Balt permit. Depart Import Injury	1	21. Signature of Funeral Service	Lipe in	e			22. N EC	ame and Addres	s of Facili	åļ Ch	apel,	P.A			7 01100
Physician	V	23a. Part I. Enter the disease, or	compli	cations that ca	used the	e death. Do not e	132	96 Charii	ע ענו	rive,	Manci	nest	er, Mar	Ap	nd 21102 oproximate Interval
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<b>₹</b> :aminer		or condition resulting in death)	_	ue to (or as a		ence of):									-
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in of Vital Records, P.O. Box 6876i ing Physician: The law requires that the death certificate After this certificate has been signed by the attending phytuneral director, page 2 should be detached for use as the this: To Be Completed by Physician/Min.		Part II. Other significant condi	tions (	contributing to	death bi	ut not resulting i	n the u	inderlying cause	given in F	art I.			✓ No 3 F		4 Unknown
ds, 1 equires and be											24a. Wa				y findings available
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Vital Vital ysician his cert directo	וֹ בֿ	25. Was case referred to medical examiner?		spital: 1 Ir	npatient	2 ER/Out	patient		Other;		Home 5	Resid	lence 6 🗸 O	ther: Sce	ene
n of V ding Phy After th funeral c	1	1 Yes 2 No 27. Manner of Death		28a Date o	of Injury	28b Tii			ury at Wor			e how in	jury occurred		
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Division o spital or Attending ours after death. reral Director: After filled in by the func Certification:	Ĭ	3 Suicide 6 Cou	ld not be	28e Place			-	et, factory, office	building, e		or Town	State)			Route Number, City
D ospital hours uneral y filled	۱ ۱	4 Homicide	rmined	(Specify)					1-1				ton Ave., Reis		vn, Md.
Division of Vital Records, P.O. Box 6876  To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours attended that To the Tenneral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the tendical Certification: To Be Commleted by Physician/Mi	2	(Check only Certifying F	aminer:		f examin	-		red at the time, o ion, in my opinio							use(s)
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d.	1	XI COM	1	11	/			0.0	.M.E.			Jul	ly 6, 2007		
611		30. Name and address of person	1	/			Don	n Street Pal	ltimore	MD 242	201				
<i>')</i>		Susan Hogan MD.  31. Date filed (Month, Day, Year)		tant Medica		Miner 111 Signature	ren	n Street, Bal	uniore,	1VID 2 12	.01				
State Registra	~	III A	g 20	07 /	Alla.	, St.	Spa	all!							
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			1 - For State Registrar	State of M	arylan		artmer <i>rtificat</i>			and M		giene Reg. No.	07	21883
	Diversion		1. Decedent's Name (First, Middle,	Last)							2. Date of Dea		Year	3. Time of Death
	Physici /Medic	_	Dorothy M.	Foehrkolb							July 4			10:40 a M
	Examir		4a. Facility Name (If not institution, g				4b. City,	Town, or	Location o	of Death			nty of Death	
			Genesis Heritag					ndalk					timor	
*	Funeral		,	1 □ M 2 ਓ F		last birthday) Yrs.	Months Months	1 Year Days	If Under:	Min.	8. Date of Birt (Month, Day	h v, <i>Year)</i>	9. Birth Cor	nplace (State or Foreign untry)
- 1	Director		220-03-5720 Usual Residence of Decedent	- 4	37	113.					Oct 29,	1919	Penr	nsylvania
	land ow		10a. State 10b. County		10c. Cit	y, Town or Lo	cation	_						10d. Inside City Limits
	Man Feb	to	MD Baltim	ore				Esse	X					1 ☐ Yes 2 № No
	within 72 hours atter death with the Maryland ene. than "natural", or items 23e or 28e-f ehow than "natural", or items train be notified at	Director	10e. Street and Number				10f. Zip	Code				10g. Citizen	of What Cou	untry?
	th wit	a D	1813 Old Easter	n Avenue			2	1221				US	3 Δ	
	dea	Funeral	11. Marital Status	12. Was Decedent Armed Forces	Ever in U	.S. 13.			spanic Orig	gin? (Spe	cify Yes or No- Rican, etc.)	14. F	Race - Amer	
92	or It	F	1 Never Married 2 Married				1 ☐ Yes		Specify:	, 1 001101	moarr, erc.)		Black, White	
Ö	ural',	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:								Spe	<sup>cify</sup> Whit	e
5	"nat	Completed	15. Decedent's (Specify only highest of	Education grade completed)		16a. Deced	dent's Usu kind of wo DO NOT u	rk done di	urina most	of working	ng	16b. Kind of	f Business/I	ndustry
2	withii ene. than	m C	Elementary/Secondary (0-12)	College (1-4or	5+)			ĺ						
0	Hygin bther ent.		17. Father's Name (First, Middle, La	st)		Home	emake		18. Mothe	r's Name	(First, Middle,		)wn Ho	me
an	d be antal	To Be	John Gingher Si								Nickel			
Ž	d 2 should be tiled within 72 hours atter death with the Marylan in and Mental Hygiene. 7 is marked other than "natural", or Items 23e or 28e-f ehow traumatic event, it a Medical Exercities in traumatic event.	-	19a. Informant's Name/Relationship			19b. Mailir	ng Address	(Street a			/ Route Numbe	r. City or Tov	vn. State. Zi	ip Code)
Š	コニトコ		Jerome Foehrkoll	, SrSon		1					MD 210		, ,	,
ē,	of Healt item 2 other		20a. Method of Disposition		20b. P	lace of Dispo	sition (Nar	ne of			ate	20c. Locatio	n - City or T	own, State
Ē	Pages nent of int: if it iry or o		1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe	☐Removal from State cify)	0al	clawn (	Cemet	ery	1	7/7/	2007	Baltin	ore,	Maryland
Baltimore, Maryland 21215-0036	permit. Page Department of Important: If any Injury of		21. Signature of Funeral Service Lic	ensee		62	2. Name ar 224 E	aster	s of Facility	Char enue	rles S. Baltim	Zeile	r & S	on 24
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	/Medical		resulting in death)	Due to (or as	a conseq	uence of):	. 1 / C	>	16	1403				
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80	death certificate be executed e attending physicien and d tor use as the burial-transit	dlcai		d. 10/100	L(X)	121//	01-							
ŏ	leath certific attending p	Iclan/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome								23d	Date of deliv	rerv
ň	death a atte	Cas	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a			Ectopic pr Other (sp						Month	Day Year
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ν̈́ T	w requires that the de been signed by the i should be detached		Part II. Other significant conditions	contributing to death b	ut not resu	ulting in the ur	nderlying c	ause giver	n in Part I.		23e. Did to	bacco use co	ontribute to	the cause of death?
cord	requires een sign hould be										1 □ Y	es 2□No	3 ☐ Pro	bably 4 Dunknown
ပ္မ	2 8 8	Completed									24a. Was a		b. Were aut	opsy findings available
r	o - o	ĕ									autop. perfor		death?	ompletion of cause of
IIa	ilcien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?						26. Place	of Death	Check only or			
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	ing P	ü	27. Manner of Death 1 ☐ Matural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry y Yea <i>r)</i>	28b. Time of Injury		8c. Injury Work?	at ?	2	8d. Describe h			
200	tend leath tor: / the t	cati	2 Accident investigate 3 Suicide 6 Could not	he			М		es 2 🗆 N					
DIVISION	or At atter of Direction by	ertification;	4 Homicide determine		ury - At ho c. <i>(Specif</i> y	ome, farm, stre /)	eet, factory	r, office		2	8f. Location (S City or Tow		m <i>ber or Rur</i>	al Route Number,
	pitel ours a erel I	O L	29a. Certifier 1 Certifying F	Dhysisian: To the best	of my leng					4 - 1				
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	To the Hospitel or Attending Physic within 24 bours atter death. To the Funerel Director: After this oc completely tilled in by the funeral director.	Married Townson	29b. Signature and title of certifier		<u> </u>		290	. License	number		2	9d. Date sig	ned (Month,	Day, Year)
	-		) ( and in A.	1, 1	1000	MI		ハっ	71	SP		7/1	10-	7
6	Y	-	30, Name and address of person wh	o completed earse of o	leath (Item	23a) (Type. I	Print)				,	1/0	10/	
J			Savicada	165/10	10	2 M	ale	de	1 la	a	Duis	Sall	Ru	2/222
4/0	Sta	e	31. Date filed (Month, Day, Year)	32. Registr	ar's Signa	ture	A.		-					
**	Registr	ar	JUL n 9	2007	148_1	D: 1	reals	,						

07-04999 Alvin Louis Garner Please Type o State

or Print in Black Indelik of Maryland / Departme Certifica	ole Ink. Ensure All C nt of Health and Ment te of Death	<b>Sopies Are Legible.</b> tal Hygiene	20	07 2100	) ]
Alvin Louis Garner	Carner	2. Date of Death  Month  Day  June 30, 2007	Year	3. Time of Death 2105 hrs	
ta-at and number)	Ab City Town or Location of	of Death 4c. Co	ounty of Deat	th	

	Р.	For State		ficate of I	Death			g. No.		
Physician	<b>/</b> 1	. Decedent's Name (First, Middle,Last)	in Louis Garne			1	2. Date of Deatl Month	Day	Year	3. Time of Death 2105 hrs
ledical Examine		Alvin L.			cner o. City, Town, or Lo	acation of Death	June 30, 2		nty of Death	
	4	a. Facility Name (if not institution, give street a Swallow Falls State Park	and number)	40	Oakland	ocation of Death		Garre		1
	_		7. Age (In yrs. las	t hirthday)	If Under 1 Year	If Under 24Hrs.	8. Date of Birt	h(MM/DD/YY		nplace (State or
Funeral Director		218_65_2525	40		Months Days	Hours Min.	11/20/	1963	Foreigr Cou	n intry) NC
Director		246-11-0208 1X M 2	F	Yrs.		,				
Company of the same of the sam		Jsual Residence of Decedent  0a. State 10b. County	10c. City, T	own or Location	n					10d. Inside City Limits
<b>*</b> ,		VA Virginia Beach	City	V	irginia	Beach				1 X Yes 2 No
Maryland 28a-f show datonce.	٩	0e. Street and Number			10f. Zip Code		1	0g. Citizen of		try?
he Mary		1804 Brotman court			2346	4			USA	
- 00 -		1. Marital Status 12. W	as Decedent Ever in U.S	13. Was	Decedent of Hisp	anic Origin? ( Spe	ecify Yes or No			can Indian, Black,
ath w items	45		med Forces?	If Ye	s, specify Cuban,	Mexican, Puerto	Rican, etc.)	٧. ا	/hite, etc.	Lack
i	-	3 Widowed 4 X Divorced If Yes, C		1	Yes 2X No	specify:		Spec	ify:	Lack
o = = =	핡-	15. Decedent's Education (Specify only higher	S'	16a. Decedent	s Usual Occupationst of working life.	on (Give kind of w	ork done	16b. Kind o	f Business/Ir	ndustry
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15-0036 filed within 72 h Hygiene. d other than "n		17. Father's Name (First, Middle, Last) Herbert Garner			1	8.Mother's Name Musir T	(First, Middle, I <b>urner</b>	Maiden Surna	ame)	
be fi	m	The second section is a		Taol: Madina	Address (Street	and Number or C	Pural Pouta Nur	mber City or	Town State	Zin Code)
D 21 hould and Me is ma	٩	19a. Informant's Name/Relationship (Type, Pri Noy R. Garner / Brot	her	1804	Brotman	Court,	Virgin	ia Bea	ch, V	A 23464
imore, MD 2 Pages I and 2 shoul nent of Health and I ant: If item 27 is a nother traumatic	-	20a. Method of Disposition		l .	tion (Name of cen		Date			Town, State
SELS of He Fite	- 1	1 Burial 2 Cremation 3 X Rer			or place)		v7.2007	Roan	oke Ra	apids, NC
imC Page ment tant: or ot	1	4 Donation 5 Other Specify:								
Baltimore, permit. Pages I an Department of Hea Important: If iten injury or other tra		11. Signiture of Frenchal Service Licensee V	ictor P. Do	oa   "Cl	ame and Address narles L. 501 E. Fo	Stevens	s Funer	al Hom	e, Inc	58
Appropriate the second second	+	23a. Part I. Enter the disease, or complication	s that caused the death.	Do not enter th	01 E. Forme mode of dying,	such as cardiac o	r respiratory ar	rest, shock, c	r heart	Approximate Interval
Physician Medical	J	failure. List only one cause on each line	owning complic							Between Onset and Death
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Box 68 e death certif the attending ed for use as	Physician	1 Yes 2 No 9 Unknown g	Unknown	5 O	her (Specify)					
b. B the de	된	Part II. Other significant conditions contri		esulting in the	underlying cause (	given in Part I.				the cause of death?
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ds, equire een si	ted						24a. Wa	s an		utopsy findings available completion of cause of
SOF faw ro has b	힐							formed?	death?	
Rec The ficate page	Completed				26 Place	e of Death (Check		2 110		65 2 110
tal ician: certi	Be	25. Was case referred to medical examiner? Hospital	il: 1 Inpatient 2	ER/Outpatien	-	0.0	ng Home 5	Residence	6 <b>V</b> Oth	er: Scene
f Vi	٤	1 ✓ Yes 2 No 27. Manner of Death 2	Ba. Date of Injury (Month, Day,Year)	28b. Time of		ry at Work?	28d. Describ	e how injury o	occurred	
n o	<u>e</u>	1 Natural 5 Pending	(Month, Day, Year) 6/30/2007	Fnd 9:0	05 rm 1	Yes 2 XNo	subject	drowne	d	
Sional Arter Arter r deat ector by th	cat	2 X Accident Investigation	8e. Place of Injury - At h			building, etc.	28f. Location	(Street and	Number or F	Rural Route Number, City
Division of Vital Records, P.O. ral or strending Physician: The law requires that the rs after death.  "I Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	Certification:	3 Suicide 6 Could not be determined	(Specify) rive	er			Swallow	Falls	State P	ark Oakland, M
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit		29a Certifier	o the best of my knowled	ige, death occu	rred at the time, d	ate and place, an	d due to the ca	use(s) and m	anner as str	ated.
To the I within 2 To the I complete	Medical	one) 2 Medical Examiner: On the	ne basis of examination a manner stated.	and/or investiga	ation, in my opinio	n, death occurred	at the time, da	te and place,	and due to	tne cause(s)
wii Yo	Me	29b. Signature and title of certifier			29c. Licen				- '	fonth, Day, Year)
		forh Je	1 mm		0.0	.M.E.		July 1,	, 2007	
		30. Name and address of person who compl	eted cause of death (Iter		_		- D 04604			
$(   0 \rangle )$			stant Medical Exan		Penn Street.	, Baitimore, M	21201 עון			
	ate	40 00 07 07 01 043 0	32. Registrar's Signat	tures A	الكان					
Regist	TO I	1111 0 9 2007	The state of the s	- 17						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) July 2,2007 **Physician** 12:30 PM Thelma Marie Goad /Medical County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore Parkville 2704 Alden Road Year) 9. Birthplace (State or Foreign York, PA If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 ☐ M 2 💢 F 84 Yrs. 183-14-8250 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location Parkville 10d. Inside City Limits 10b. County show r 28a-f show notified at Baltimore MD 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ms 23a or must be r 21234 USA 2704 Alden Road Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) r than "natural", or items the Medical Examiner mu 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examine and. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: White Baltimore, Maryland 21215-0036 Specify: þ 3 ₩Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) N/A Elementary/Secondary (0-12) Sears Department Manager 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Bisker UNKNOWN ည 19a. Informant's Name/Relationship (Type. Print)
Wayne Goad- Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
26 Kitzburel Rd. Parkton, MD 21120 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition competery, crematory or other place)
Nomissi I e United
Includes Autron Cenetery 1 Burial 2 □ Cremation 3 □ Removal from State 7-6-07 White Hall, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lineral Chapel & Cremation Services Parkville 8800 Harford Rd. Parkville, MD 21234 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 No 4□Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 9 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has the irector, page 2 s autopsy performed? Yes 250 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 1 Natural 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After (Month, Day Year) 5 Pending investigation within 24 hours are: 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 📂 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and (Item 23a) (Type, Print) anse 32 Rehistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 11em 16b per fh e869 7-9-07 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Day Year Month 6:01 AM **ESTHER** July **GUTMANN** 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Balfimore City
If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Hospital Paltimore Sinai 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 1 □ M 2 K F 216-09-2603 100 03/09/1907 MDUsual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10h. County 1 X Yes 2 □ No N/A BALTIMORE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 6004 PIMLICO ROAD 21209 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 💢 No Specify: Specify: WHITE 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry own home College (1-4or 5+) 5+ Elementary/Secondary (0-12) HOUSEWIFE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ISRAEL GOMBOROV HANNAH GOLD 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MINNIE OPPENHEIMER/SISTER 7017 WALLIS AVENUE, BALTIMORE, MD 21215 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State BETH TFILOH CONG. 07/06/2007 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSO
8900\_REISTERSTOWN ROAD - PI
23a. Parti, Enter he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. SOL LEVINSON & BROS., INC. 8900-REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) day Due to (of as a consequence of): reunionic Sequentially list conditions, to the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of): IF FEMALE: If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an Was a. autopsy performed Yes 201 1☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1. Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or any Injury or other traumatic event, the Medical Examiner must be read Injury or other traumatic event, the Medical Examiner must be read. Baltimore, Maryland 21215-0036 **Physician** /Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division or Vital Records, P.O. Box 68760,

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Physician

/Medical

**Examiner** 

**Funeral** 

Director

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Director

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death with the Maryland

Examiner Physician/Medical Completed by Be Certification: To Medical

State Registrar 29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day,

and manner stated.

ne

2007 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mr D

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

18478

29d. Date signed (Month, Day, Year)

Sinai Hospital of Badfarmore

Amend #1,pen/ID, #19a,per/H, C870, 8/23/07 IT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death . . 0 > 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Everett Horton, Sr. Everett B. Horton Physician 6/30/2007 1:00pm<sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) Washington Adventist Hospital 4b. City, Town, or Location of Death County of Death **Examiner** Montgomery Tacoma Park MD 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** Min. Days 1**XX**M 2 □ F Months Hours 424-26-6387 75 12/22/1931 Director ALUsual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland eath and Mental Hyglene.

M 27 is marked other than "natural", or items 23a or 28a-f show ner 12 is marked other than "natural", or items 23a or 28a-f show her fraumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County r 28a-f show notified at Prince George's MD Hyattsville 1XYes 2 No Director 10f. Zip Code 20783 10g. Citizen of What Country? USA 10e. Street and Number 1801 Metzerott "natural", or items 23a or Road by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 12 Yes 2 □ No If Yes, Give Year or Dates: 1948–1957 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manager Garden Shop 17. Father's Name (First, Middle, Last)
Everett Spencer Horton 18. Mother's Name (First, Middle, Maiden Surname)
Marie Bragg Be ၉ 19a. Informant's Name/Relationship (Type. Print)
Everette Horton Jr. 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15105 Joppa Place, Bowie, MD 20721 permit. Pages 1 and 2::
Department of Health a:
important: if item 27 is
any Injury or other trau Everett Carlos Horton 20b. Place of Disposition (Name of cemetery, crematory or other place Glenwood Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3XXX Removal from State July 6, 2007 Huntsville, AL 4 Donation 5 Dother (Specify) 22 Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Avenue, Baltimore MD 21230 21. Signature of Euneral Service Licensee Victor P. Doda 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** DIOPULMONARY /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) physician and s the burial-transit UMBT Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical 88 IF FEMALE: nse s 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) signed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be MENETIA 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed' 2 🔀 No 2X No 1 TYes or Attending Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) To Hospital: 1 Yes 2 No 1 🗷 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation To the Funeral Director: completely filled in by the 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral I To the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 200 t 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TREOVER PARKWAY GREET-BELT MARYLAND 2070 7325A DIAKA

Registrar

State

31. Date filed (Month, Day, Year)

32. Regis

2007

# 07-05173

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hydiene

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Phys	iciar		eqistrar . Decedent's Name (First, Middle,Last)		-	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				te of Death	ay Year	3. Time	of Death
Medical Exa		er	Lewis Monroe Hale,						Jul	y 6, 2007			l6 hrs
1		4	la. Facility Name (if not institution, give s Carroll Hospital Center	treet and number)			, Town, or stminste	Location of er	Death		4c. County of D Carroll	eam	
Funer	ei		5. Social Security Number 6. Sex	7. Age (Ir	yrs. last	birthday) If U	nder 1 Yea	r If Under	24Hrs. 8. I	Date of Birth(	MM/DD/YYYY) 9	. Birthplace (	State or
Direct		┖		1 2 F		33 Yrs. Mo	nths Day	s Hours	Min. Ma	ar. 29	, 1974	oreign Country) [\	Maryland
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more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland near of Haland Mental Hygiene Maryland of the Than "matural", or items 23a or 28a-f she	must be notified at once.		11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S.	13. Was Dec	edent of Hi	spanic Origi n, Mexican,	n? (Specify Puerto Ricar	Yes or No-	14. Race - A White, e	American Indi	ian, Black,
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003( within jene	Medic	틹	12th 17. Father's Name (First, Middle, Last)			Logger		18 Mother's	s Name (Firs		Lumber		
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MD 21215-0036 at a should be filed within 7 linkin 7 linkin 7 linkin 7 linkin 7 linkin 7 linkin 7 linkin 7 linkin 7 linkin 1 link	ic ever	라	Lewis Monroe Hale, 19a. Informant's Name/Relationship (Typ	pe, Print )		19b. Mailing Add	ess (Stre	et and Numi	ber or Rural	Route Numb			
MD id 2 sh ulth and	auma		Dianne B. Hale (Wi	fe)	Look Di	5544 Lir			East		eboro, M 20c. Location - C		
Baltimore, MD 21215-0036 pemit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene Innortant: If tiem 27 is marked other than "natural".	ther tr		1 Burial 2 XX remation 3	Removal from State	CLE	ematory or other pla	ace)		July 9	9,			
timent	y or 0	-	4 Donation 5 Other Specify 20. Signature of Engral Service 1/cense	20	Meti	ro Cremat	-	1	2007				Maryland
Bal permi Depar	ië		Xann W. Maun			Eckha 3296	ardt Char	Funera mil Dr	al Cha cive;	pel, F Manche	A. ester, M	arylan	d 21102
Physici		$\dashv$	23a Part I. Enter the disease, or complications. List only one cause on each	cations that caused the	e death. [	Do not enter the mo	de of dying	, such as ca	ardiac or res	piratory arres	t, shock, or hear	t Appr	roximate interval ween Onset and
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30x 68760, death certificate be executed	burial	Physician/Medical	X UNPENDED X	#18 perFH.	#1.23	a.27.28a-f.	pe <u>rM</u>	E <b>.</b> g871.	9/19/0	7 TT	23d. Date of d	elivery	
3876 rtificat	as the	an/R	23b. Was decedent pregnant in the past 12 months?	1 Live birth		2 Fetal de	ath 3	Ectopic	pregnancy		Month	Day	Year
Box 687 e death certific	for use	sici	1 Yes 2 No 9 Unknown	4 Pregnant at tir	ne of dea	th 5 Other (	Specify)				Ť		
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Division of Vital Records, P.O ral or Attending Physician: The law requires that the state death.	be del	g b									2 No 3		
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tal F	ector,	Be	25. Was case referred to medical examiner?	ospital:	2	ED/Outpetiont 3	26.Pla DOA	ce of Death	(Check only Nursing He		Residence 6	Other:	
of Vi ing Physic	eral dir	ှု	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Injury (Month, Day,Yea		ER/Outpatient 3 28b. Time of Injury		jury at Work			ow injury occurre		
on C	filled in by the funeral	ţį	1 Natural 5 Pending	2/21/2006	IT)	unk	1 X	Yes 2		ree str	uck deceas	æd whil	e at work
VISI or Atte	in by t	ifica	2 X Accident Investigation 3 Suicide 6 Could not be	28e. Place of Injur	ry - At ho	me, farm, street, fa	ctory, office	building, et	tc. 28f	. Location (S or Town, St	treet and Numbe ate)	r or Rural Ro	ute Number, City
Dj spital	filled	Certification:	4 Homicide determined (Specify) unk unk										
Division of Vital Records, P.O. E to the Hospital or Attending Physician: The law requires that the within 24 hours after death.	completely filled	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)										
To the	COT	Med	29b. Signature and title of certifier	and manner stated.				nse number	ARTS-		29d. Date signe		
			The day U.	They ?	n	un	0.0	C.M.E.	× 2		July 7, 2007	7	
_			80. Name and address of person who completed cause of death (Item 23a)  Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201										
			Theodore M. King, Jr., MD 31. Date filed (Morith, Day, Year)	32. Fegistrar's		re /				2 1201			
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07-04881 Irene Heredia

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ene meredia	State of Maryland / Department of Health and Mental  1- For State  Certificate of Death	Reg. No.								
Physician	Registrar	2. Date of Death 3. Time of Death								
Medical Examine	-10110 Interest included	June 27, 2007 0226 hrs								
	4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of De Powers Lane @ Rolling Road  Woodlawn	eath 4c. County of Death Baltimore County								
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24									
Director	Usual Residence of Decedent	March 16, 1985 Country Germany								
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the Maryland a or 28a-f sh tiffed at once	10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?								
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T. pe a s o		or Rural Route Number, City or Town, State, Zip Code)								
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Baltimore, MD 2 permit Pages I and 2 shou Department of Health and M Important: If item 27 is n injury or other traumatic		iller-Dippel Funeral Home d Baltimore, Maryland 21206								
Physician	23a Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart diging. List only one cause on each line.  Approximate Interval									
/Medical raminer	Immediate Cause (Final disease a. Multiple Injuries Death									
<b>A</b>	or condition resulting in death)  Due to (or as a consequence of):									
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ision Attendin r death. rector: A by the fu	1 Natural 5 Pending Jun 27, 2007 Pending Investigation Investigation	Passenger auto fixed object collision								
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lospita 4 hours 7 untera ely fills	29a. Certifier a Country of the Country of the Country of the time date and the country of the time date and the country of the Country of th									
Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitional Certification: To Bo Completed the Divisional Madical Expension	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
		29d. Date signed (Month, Day, Year)								
	fatulain O.C.M.E.	June 27, 2007								
27	30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201									
	State 31. Date filed (Month, Day, Year) 32. Registrar's Signature									
Registra	ar JUL 0 9 2001 Bloom A. Coastes									

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Amend #18, perInf, 0869, 7/9/0/TT

Registrar

Cortificate of Department of Health and Mental Hygiene Cortificate of Department of Department of Health and Mental Hygiene 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** p <sup>M</sup> Anna Holy July 1, 2007 5:59 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Towson Baltimore Gilchrist Hospice Center
Social Security Number 6. Sex 7. A If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) . Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 🛛 F 68 Yrs. 1939 June 6, Maryland 220-36-2546 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County must be notified at MD Baltimore Perry Hall 1 ☐Yes 217 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3800 Meghan Drive Apt 1C 21236 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner. Black, White, etc. 1 ☐ Yes 22K No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ Specify: White 3 NVidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Underwriter Insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nicholas Caruccio Antoinette Unknown LaMacchia ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kevin Holy- Son 5 Class Court Baltimore, MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Parkwood Cemetery 7/6/07 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Miller-Dippel Funeral Home 6415 Belair Road Baltimore, MD 21206 23a. Part Ther the dease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart-failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ears ) Varian resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine and burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical as the IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) ed by the a detached for 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 27 No 1 ☐ Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy performed? res 2 No 1□ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 21**X** No 1 Tyes ို 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manper of Death Certification: 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of ceglifier 29c. License number ung

State Registrar 31. Date filed (Month, Day, Near)

DHMH 17 Rev 1/2001

6701 N.Ch

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6BMC

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** July 2, 2007 8:15 a Irvin H. Hoffman /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 18 Cypress Lane Middle River Baltimore 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1<del>√</del>2 M 2□ F Yrs. 17, 85 1921 Maryland Director 215-18-0713 Usual Residence of Decedent with the Maryland 10a. State 10b. Count 10c. City. Town or Location 10d, Inside City Limits ir than "natural", or itams 23s or 28e-f show the Medical Examinar must be notified at MD Yes 2 No N/A Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death a Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Exacts per interest once. 4519 Mary Avenue 21206 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify:White þ 3X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Insurance Adjuster Insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Eli Leonard Hoffman Lillian Roberts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet Cullings- Daughter 18 Cypress Lane Middle River, Maryland 21220 of Disposition (Name of Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 7/6/2007 Gardens of Faith Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Miller-Dippel Funeral Home 21. Signature of Funeral Service Licensee 6415 Belair Road Baltimore, Maryland 21206 23a. Pad1 Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ONGE STIVE 4 CARS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CARDIOMYOPATA Schenic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner this certificate has been signed by the ettending physicien and al director, page 2 should be detached for use as the burial-transit The law requires that the death certificate be executed yocaroia 1 that initiated events resulting in death) Last to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 | Yes 2 | No 3 | Probably 4 Manknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yes 2 2 No 1 Tyes To the Hospitel or Attending Physician: within 24 hours after death. To the Funerel Director: After this certifica the funeral director, 25. Was case referred to medical 26. Place of Death | Check only one) DACKHHOLS Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending М 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760.

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

30. Name address of parson who completed cause of death (Item 23a) (Type, Print) AMPOELL 32. Registrar's Signature

D0019245

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 17 per fb 8869 7-9-07 yt. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month **Physician** Jones Mont 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and num 4b. City, Town, or Location of Death Examiner Maryland Medical Center 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months 1 X M 2 □ F Yrs. UNK 07-02-2007 Director MD Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or itsms 23a or 28a-f show traumatic svent, the Madical Examiner must be notified at BALTIMORE MD Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funerai 2212 SIDNEY AVENUE 21230 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 X Never Married 2 ☐ Married Specif BLACK 1 ☐ Yes 2X No Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry mit. Pages 1 and 2 should be fited within 72 lartment of Health and Mental Hygiene.
ortant: If itsm 27 is marked other than "nation]ury or other traumatic svent, the Madian Elementary/Secondary (0-12) **N/A** College (1-4or 5+) N/A N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be NICOLE WITHERSPOON LLOYD JEFFREY JONES, JR. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2212 STDNLY AVENUE, BALTTMORE, MD 21230
Other Disposition (Name of Date 20c. Location - City or Town, State NICOLE WITHERSPOON/MOTHER 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other) 07-09-07 permit. Page Department of Important: If any injury or once. METRO CREMATORY BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC Romas 1701 LAURENS ST., BALTO., MD 21217 23a. Part1 I niter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ischemia Physician -omplete Bowel disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner jastroschisis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 □ Yes 2 □ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9∏ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death Check only one 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient ٩ 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Naturat 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier

The law requires that the death certificate be executed attending physician and for use as the burial-tran Division of Vital Records, P.O. Box 68760, been signed by the should be detached certificate Attending Physician: hours after death. Ineral Director: After this y filled in by the funeral di inis 6 To the Hospital within 24 hours a To the Funeral C

with the Maryland

hours after death

Baltimore, Maryland 21215-0036

State Registrar

29b. Signature and title of certifier

31. Date filed (Month Day, Year)

amuyide

Mobelali tamuulde

JUL 0 9 200

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

reene

29c. License number

P#16770

29d. Date signed (Month, Day, Year)

Street, N5NG8, Ballimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. / 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 2007 ora 0 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. Counfy of Death **Examiner** BALTIMOR Timonium 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 216-01-9919 Months 1□M 2**X**F Days Hours Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at BALTIMORE 1 ☐ Yes 2 No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3325 21234 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Maritai Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Yes 2 No if Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Whit Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health a Important: If item 27 is any Injury or other trau once. MO 21234 MOVE Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City of Town, State 3 ☐Removal from State 1 Burial 2 ☐ Cremation Moreland Mem BALTIMORE 4 ☐ Donation 5 ☐ Other (Specify) 10/07 21. Signature of Funeral Service strutimore MO 2123 23a. Part1. Enter the disease shock, or heart failure. plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Caus (Final disease or condition resulting in death) **Physician** CONGESTIVE HEART FAILURE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: . If yes, outcome pf pregnancy 1□Live birth 2□Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 🗖 No Month 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No has autopsy performed? res 2 No certificate ha To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural
2 ☐ Accident 5 Pending investigation (Month, Day Year) Injury 4 hours after death. Funeral Director: A ely filled in by the fi 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the 29a. Certifier (Check of one) er: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) State Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician 0355 M 2007 ALVERTA JENNINGS /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A UNION MEMORIAL HOSPITAL BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6–26–1934 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 🕅 F Yrs. MARYLAND 73 Director 216-28-1306 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show must be notified at 1 XYes 2 No Director N/A BALTIMORE MD. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23a or 21217 USA 107 N. CAREY ST. APT 2 Funeral 14 Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 'natural", or items 11 Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any Injury or other traumatic event, the Medical Examiner and. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married BLACK Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify Specify: ≥ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SOCIAL SECURITY -12-ASSISTANT MANAGER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be IDA MAE WILLIAMS RAYMOND JACKSON ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 107 N. CAREY ST. APT 2 BALTIMORE, MARYLAND 21217 WILLIAM JENNINGS (HUSBAND) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 7-5-2007 METRO CREMATORY BALTIMORE, MARYLAND 4 □ Donation /5 □ Other (Specify) D. HIBNER. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee JONATHAN 1721-27 N, MONROE ST, BALTIMORE, MARYLAND 21217 23a. Part / Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Physician/Medical 10 IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autonsy performe Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2⊠No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 3 Suicide

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, after death filled in by within 24 hours at To the Funeral Completely filled i

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 2 O

State Registrar

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) tastmi mo ZHOA113

N. ENTAW STAME 308 BALTIMONE

31. Date filed (Month, Day, Year)

2007 JUL 0 9

32 Registrar's Signature

			1 - For State Registrar	State of Maryland / Dep	partment of Health and ertificate of Death	•	2007 21900
	o Dharaini		Decedent's Name (First, Middle, La			2. Date of Death Month Day	3. Time of Death
	Physici /Medio		X/0170	Lex, Sr		JULY 0	5 2007 430 PM
7	Examir	er	4a. Facility Name (If not institution, giv		4b. City, Town, or Location of Deat	h 4c.	County of Death
	Funeral		5. Social Security Number 6.5		If Under 1 Year   If Under 24 Hrs	8. Date of Birth	9. Birthplace (State or Foreign Country)
	Director		213-62-0454 Usual Residence of Decedent	M 2□F 52 Yrs.	Months Days Hours Min.	9. Date of Birth O9-20-195	54 country MD
	with the Maryland a or 28a-1 show	o	10a. State 10b. County	10c. City, Town or L			10d. Inside City Limits 1 X Yes 2 □ No
	or 28a-	Funeral Director	10e. Street and Number	Λ	10f. Zip Code	10g. Cit	izen of What Country?
	death with Ims 23a or	erai	1+19 Collingtor	12 Was Decedent Ever in U.S. 13	Was Decedent of Hispanic Origin? (S	Specify Yes or No-	USH 14. Race - American Indian,
980	or Ita	þ	1 □ Never Married 21 Married 3 □ Widowed 4 □ Divorced	Armed Forces?  1 □ Yes 2 No If Yes, Give Year or Dates:	. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 No Specify:	to Rican, etc.)	Black, White, etc.  Specify: Black
15-0	n 72 hour "natural" cuical Ex	leted	15. Decedent's E (Specify only highest gra	ducation 16a. Deci ade completed) (Giv.	edent's Usual Occupation e kind of work done during most of wo _DO NOT use retired)	rking 16b. K	ind of Business/Industry
Maryland 21215-0036	77 E L	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Burner	<u>\$</u>	tap Yard
nd	\$ <b>₽</b> ₽ ₽	Be	17. Father's Name (First, Middle, Last	)	18. Mother's Na	me (First, Middle, Maiden	Surname)
II Y	should by	유	John Rey Jea. Informant's Name/Relationship (	Type Print)	line of dress (Street and Number or F	ural Route Number, City of	or Town, State, Zip Code)
	s 1 and 2 should f Health and Men item 27 ie marke other traumatic	135 0 33	Nonne M. Kei	1 (Wite) 1719	Collington Ave.	- ·	ND 21213
Baltimore,	00=5		20a. Method of Disposition  1 Burial 2 Cremation 3	Tremovariion State	position (Name of permatory or other place)	Date 20c. Lo	ocation - City or Town, State
altin	permit. Pag Department Important: any injury c		'4 □ Donation 5 □ Other (Special 21. Signature of Funeral Service Lice	10 10 111	Morial lark	ne funera	1 Services
8	Dep Character Person		Vaughe C	· Oreere	151 Batto. Nat	14:16 B	alto, mD 21229
	Discontinuo		23a. Part1. Enter ing disease, or com shock, or he in failure. List only Immediate Cause (Final	plications that caused the death. Do not er one cause on each line.	1 1 1	c or respiratory arrest,	Approximate Interval Between Onset and Death
7	Physician /Medical		disease or condition resulting in death)	aDue to (or as a consequence of):	tocellular	Carcino	Will 3 month
	Examiner	-	Sequentially list conditions,	b. Due to (or as a consequence of):			
A	uted id ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Ur Johning Cause (Disease or injury that initiated events	6			
760,4	te be executed ysician and se burial-transit		resulting in death) Last	Due to (or as a consequence of):			
6876	0 5 0	edicai	÷.,	d			
Box	requires that the death certificat een signed by the attending phy nould be detached for use as th	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
P.0	that the de ed by the detached			contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco u	use contribute to the cause of death?
Records,	w requires tha been signed should be del	ed by	no	NE		1 ☐ Yes 2	No 3 ☐ Probably 4 ☐ Unknown
eco		Completed				24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
E B	eicien: The law certificate has b irector, page 2 s					performed? 1 ☐ Yes 2 No	death?
Vital	Physicien: this certific ral director,	o Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital: 1 Inpatient MER/Outpatie		ath (Check only one)	- CO.
of	Phy rthis ral d	H- 1	27. Manner of Death	28a. Date of Injury (Month, Day Year)  28b. Time Injury		lome 5 Residence	
sion	Attending F r death. actor: After by the funera	catio	Natural 5 Pending 2 Accident investigatio 3 Suicide 6 Could not b	n	M 1 Yes 2 No		
Division	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	Certification:	3 Suicide 6 Could not b 4 Homicide determined		treet, factory, office	28f. Location (Street an City or Town, State	d Number or Rural Route Number,
	a Hospi 24 hour a Funar etely fill	Medicai	29a. Certifier (Check only one) Certifying Ph	nysician: To the best of my knowledge, dea niner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place nvestigation, in my opinion, death occurred.	e, and due to the cause(s) arred at the time, date and	and manner as stated. I place, and due to the cause(s)
	To the within To the Comple	Me	29b. Signature and title of certifier	/ := /	29c. License number		te signed (Month, Day, Year)
•		3/2	Sim X	ats/100	24532	- JXI	y 5,2007
	5			completed cause of death (Item 23a) (Type	Print)  S  H  S  C  S  C  S  S  S  S  S  S  S  S  S	ct. B= 14	y 5,2007
1	Sta		31. Date filed (Month, Day, Year)	32 Registrar's Signature	nach	7 - 100	, , , , ,

DHMH 17 Rev 1/2001

07-05070 Charles Kinsev

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Zilanes Kinsey		1- For State Registrar	Certi	ificate of Dea			eg. No.	7 9190
Physici		Decedent's Name (First, Middle,Last)				Date of Dea     Month		3. Time of Death
Medical Exami	iner	Charles Dale Kinse				July 2, 20	07	2150 hrs
		4a. Facility Name (if not institution, give street a 1208 Guilford Road	nd number)		Town, or Location of Burnie	Death	4c. County of Deat Anne Arunde	
Formula		5. Social Security Number 6. Sex	7. Age (In yrs. las			24Hrs 8 Date of Bir	th(MM/DD/YYYY) 9. Bi	
Funeral Director		212–54–7706 1 XM 2		55 Yrs. Mont		1 Adim	Forei	
any		10a. State 10b. County	10c. City, T	own or Location				10d. Inside City Limits
≱	_	Maryland Anne Arunde	1 G1	en Burnie				1 Yes 2XX No
faryla:	ecto	10e. Street and Number	<del></del>	10f. Zi	p Code	1	Og. Citizen of What Cou	untry?
the N ia or '	Dir	1208 Guilford Road			21060		United St	tates
n with ms 23 be no	eral	11. Marital Status 12. Wa	s Decedent Ever in U.S. led Forces?	. 13. Was Deced		n? (Specify Yes or No		rican Indian, Black,
death or ite	Funeral Director	1 X	res 2 No			derto Nicari, etc.)	write, etc.	White
s after rral",	by	3 Widowed 4 Divorced If Yes, Given Dates:		1 Yes 2	No specify:	and of words down	Specify:	
2 hour "nate	ted	15. Decedent's Education (Specify only highes  Elementary/Secondary (0-12)  Colle	ege (1-4 or 5+)		orking life. DO NOT u		16b. Kind of Business.	rindustry
36 hin 7. than edical	ıple	9	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Carpente	r		Constru	ction
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. Iant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner.	Completed	17. Father's Name (First, Middle, Last)			18.Mother's	Name (First, Middle, I	Maiden Surname)	
219 be fill rited riked	Be	William Albert Kinse	y, Sr.	personal control			a Kasubinsk	
D 21 hould nd Me is ma	To	19a. Informant's Name/Relationship (Type, Print		1			ber, City or Town, State	
MD and 2 sho salth and 2 sho sem 27 is		William A. Kinsey, Jr 20a. Method of Disposition		1021_G1 ace of Disposition (Na		rive Glen Date	Burnie, MI 20c. Location - City o	
Ore ges la of He If its		1 Burial 2 X Cremation 3 Remo		ematory or other place		July 9,	200. Eddallon - Oity C	Town, State
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importment of Health and Mental Hygiene, matural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		4 Domation 5 Other Specify: 21. Sign were of Funeral Septice Licensee	Meta	ro Cremato	ry d Address of Facility	2007	Catonsvill	e, MD
Bal permi Depar Impo injur		21. Significate of Funeral Septice Licensee				Funeral H	ome P.A. Burnie, Md	21061
Physician		23a. Part I. Enter the disease, or corp ications to	hat caused the death. D					Approximate Interval
/Medical	-	failure. List only one cause ne ch line.  Immediate Cause (Final disease Mixe	d drug intoxi	cation (morn	hine methad	one and oxyg	rodone)	Between Onset and Death
Examiner			r as a consequence of):		HIIC IICCIA	ore and only	course)	
	_	Sequentially list conditions, b.						
	nine	nauna Enter Underlying Course	r as a consequence of):					
d d	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or	r as a consequence of):					
xecute	al	d						<del> </del>
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876 tiffcat ng ph	<u>N</u>	23h Mos decodest except in the	yes, outcome of pregna live birth	Petal death	3 Ectopic	oregnancy	23d. Date of deliver Month	y Day Year
Box 687 e death certific the attending p	sicia	1 Von 3 No 9 Unknown	Pregnant at time of	5 Other (Spe	ecify)			
BC he dea	Physician/		Jnknown	ما باسمال مسالم المسالم	ive- in Dest	1 220 Didte	bacco use contribute to	the source of death?
P.O. B ss that the d gned by the e detached	ģ	Part II. Other significant conditions contribut	ing to death but not rest	diling in the didenyin	g cause given in Part		2 No 3 Pro	
dS, P equires t en sign uld be d	Completed	-			-	24a. Was i		utopsy findings available
cords law requi has been 2 should	nple				-	autop	sy prior to	completion of cause of
tal Reco cian: The law certificate has ector, page 2 s	So					1 🗸 Yes	2 No 1 🗸 Y	es 2 No
	Be	25. Was case referred to medical examiner?	Inpatient 2 E	R/Outpatient 3	26.Place of Death (C		Residence 6 ✔ Othe	ar: Scano
of Ving Physi After this	T.	1 <b>✓</b> Yes 2 No 27. Manner of Death 28a.	Date of Injury 2	28b. Time of Injury	28c. Injury at Work?		now injury occurred	- Scene
On C	텵	Natural 5 Pending Fin	Month, Day, Year) d 7/2/2007 1	unk	1 Yes 2 X	₀ unk		
	fica	2 Accident investigation	Place of Injury - At hom		y, office building, etc.			ural Route Number, City
Division Hospital or Attene 24 hours after death Funeral Director:	Certification:	A	ecify) other—so	cene		or Town, S 1208 Gui	<sup>tate)</sup> 1dford Rd. G1	en Burnie, MD
Hosy 24 hc Fum etely 1		29a. Certifier 1 Certifying Physician: To the						
Div To the Hospital or within 24 hours afte To the Funeral Di	Medical		asis of examination and ner stated			arred at the time, date		
	Σ	29b. Signature and title of certifier		29	c. License number		29d. Date signed (Mo	onth, Day, Year)
c1		(abille)	7		O.C.M.E.		July 3, 2007	
0		<ol> <li>Name and address of person who completed Zabiullah Ali, M.D. Assistant Me</li> </ol>	caus of death (Item 23 edical Examiner	,	et, Baltimore, MI	D 21201		Į.
	ate		2. Resistrar's Signature		- Daiminore, Mi	- LILUI		
Regis	Ų.U	JUL 0 9 2007	Blown L	" Appell				

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				State of Marylar	·	ficate of			Reg. No.	07 21902
	Physici	an	1. Decedent's Name (First, Middle, Les					2. Date of D Month	Day	Year 9 PM
-	/Medio	al	4a. Facility Name (If not institution, give	King			4b. City, Town, or	ocetion of Dea		
Ť	Examir	ier	Glege Man				Luther	111 .		imore County
	Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs	8. Date of B		Birthplace (State or Foreign Country)
	Director		193-12-8557	⊠M 2□F 82	. N	Months Days	Hours Min.	April	23, 1925	Waynesboro, PA.
-	P .		Usual Residence of Decedent							
	show	_	10a. State 10b. County		ty, Town or Locat					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	the M	ect	Maryland Baltimo	re county co	ockeysvi	10f. Zip Code			10g. Citizen of V	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Be Completed by Funeral Director	13801 York Road	Apt.E11		2	1030		United	States
	er dez	nue	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	If Y	s Decedent of H es, specify Cubi	lispanic Origin? (S an, Mexicen, Puerl	pecify Yes or No Rican, etc.)	lo- 14. Rac Blac	ce - American Indian, ck, White, etc.
Maryland 21215-0020	ours after	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1⊠ Yes 2 □ No If Yes, Give Year or Dates:	<b>V.II</b> 1□	Yes 2⊠ No	Specify:		Specify	v: White
5-0	72 hc	eted	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a. Deceden (Give kin	t's Usual Occup	pation during most of word)	rking	16b. Kind of Bu	usiness/Industry
121	/ithin	ď	Elementary/Secondary (0-12)	College (1-4or 5+)					Anderso	n,Coe,& King
2	lled v Hygie her ti nt, in	ပိ	12 17. Father's Name (First, Middle, Lest)	08		Attorne	<del></del>	ne /First Middle	e, Maiden Surnan	
ano	d be f ed of	Be	Thomas King				Victoria			10)
Z	shoul mark	ဥ	19a. Informant's Name/Relationship (7	Type, Print)	19b. Mailing	Address (Street	and Number or Ru			State, Zip Code)
Ž	nd 2 alth a salth a 27 is		Mrs. Linda L. Kin	q (wife)		York Ro				ille,MD. 21030
ē,	s 1 e of Hea item outhe		20a. Method of Disposition	20b. F	Place of Dispositi cemetery, cremat	on (Name of	ce)	Date		City or Town, State
Ē	Page nent c int: if		1 ☐ Burial 2XI Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Hemovai from State	ans Fune			07/06/0	7 Fores	t Hill, Maryland
Baltimore,	permit. Departr Importa any inju		21. Signature of Funeral Service Licen	f gin	// Pea	ame and Addre	lternativ	ves Fun	eral&Cre	mation Ctr.,P.A
			23a. Part L'Enter the disease or comp	olications that caused the deat		25 York			um, Mary.	land 21093 Approximate Interval Between
-	Physician	1 2	23a. Part L'Enter the disease or comp shock, or heart failure. List only							Interval Between Onset and Death
7	/Medical		Immediate Cause (Final disease or condition	Conge	Thing !	Sport	failu Part I	11		
	Examiner		resulting in death)	a. Done to (c	or as a conseque	nce of):	7 204 00	4		
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60,	be ex cian buriel	區	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury	C						
68760,	The law requires that the death certificete be executed ate hes been signed by the attending physician end page 2 should be detached for use as the buriel-transit	Medicai Examiner	that initiated events resulting in death) Last	Due to (o	or as a consequer	nce of):				
	certific	١	L.	d						
Box	leath cer attendin d for use	Physician//	Part II. Other significant conditions co	matalle ration as almosts from an array	unistana ta aban unada		an in Florida	ook pi		ntributa to the cause of death?
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	es that igned l	by P	als heimers	Disease					, 100 2010	7
ğ	v require been sig should b	P P						24a. Wa	s an autopsy formed?	24b. Were autopsy findings available prior to
ပ္မ	e law re hes be ge 2 sh	ple								completion of cause of death?
<u> </u>		Completed						1□	Yes 25 No	1 ☐ Yes 2 ☐ No
/ita	Physician: The I r this certificate he ral director, page	Be	25. Was cese referred to medical examiner?				26. Place of Dea	ith (Check only	one)	Pro Pro DV
£	Physic this c	၉	10 103 2010			3□ DOA Oth	4 Li Nursing n	ome 5 Res		
Ę.	g ege	ig ig	27. Manner of Death  1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor	yat k? Yes 2∐No	280. Describe	how injury occur	red
Si	Attending ir deeth. ector: After by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be		ome farm street		165 2 110	28f Location	(Street end Numb	per or Rural Route Number,
Division of Vital Records,	li or A efter Direct d in b	Certification:	4 ☐ Homicide determined	building, etc. (Specif		, radiory, office			own, State)	
	To the Hospital or Attendi within 24 hours efter deeth. To the Funeral Director: A completely filled in by the fi	edicai C		rsician: To the best of my kno iner: On the basis of examina and manner stated.						
	within 2 To the comple		29b. Signature and title of certifier			29c. Licens	e number		29d. Date signe	d (Month, Dey, Yeer)
	F > F 0		her	insilh	in O	200	PAUE B	)	7/05/2	2007
	120	-	30. Name and address of person who o	ompleted cause of death (Item	n 23a) (Type, Prir	nt)			110112	
	11		A 1	PRRES MO 4	45.6	ELLWOO	PAUE B	ACTO, 6	40 21	1224
	Sta	te <sup>+</sup>	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature		1			
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			1 - For State Registrar	State of Maryland		artment of H			jiene ()		2190	3
			1. Decedent's Name (First, Middle, Last,					2. Date of Dea Month	th Day	Year	3. Time of Dea	ith
19	Physici /Medi		GERARD M.	KUREK				06	30	07	0410	М
Y	Examir		4a. Facility Name (If not institution, give			4b. City, Town, o	Location of Deat	n	4c. Count	y of Death		
	Funeral	(Signal)	FRANKLIN SQUAR 5. Social Security Number 6. Sey		St birthday) Yrs.	ROSE If Under 1 Year Months Days	DALE If Under 24 Hrs. Hours Min.	(Month, Day	Year)	9. Birthp Coun	lace (State or Fo	reign
*	Director		115-11-9808 Usual Residence of Decedent	84	113.			MAY 12	1923	MAI	RYLAND	
	yland wow		10a. State 10b. County	10c. City,	Town or Lo	cation				1	0d. Inside City Li	mits
	death with the Maryland one 23a or 28a-f ehow	to	MARYLAND N/A	BA	ALTIM	ORE					1. Yes 2 □	]No
	or 28	Director	10e. Street and Number			10f. Zip Code			l0g. Citizen of	What Cour	try?	
	23a		600 S. CONKLII	VG ST.			124			5, A.		
	er de	Funeral	-	12. Was Decedent Ever in U.S Armed Forces?	. 13. V	Vas Decedent of H Yes, specify Cuba	ispanic Órigin? (S an, Mexican, Puerl	pecify Yes or No- o Rican, etc.)	14. Ra Bla	ce - Americ ick, White,		
36	rs afte	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates:	1	☐ Yes 2X No	Specify:		Speci	fy:	76	
21215-0036	72 hours after naturel', or ite dical Executive		15. Decedent's Edu		16a. Deced	lent's Usual Occup	ation		16b. Kind of E	Business/Ind	1 L Iustry	
215	within 72 ene. then "ne	Completed	(Specify only highest grade Elementary/Secondary (0-12)		(Give	kind of work done of NOT use retired	during most of wor	rking			,	
21	giene giene er the	mo	id 1	5 +	1	MISSICI	ARY		PRIES	THO	00	
	al Hygi I other	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nar	ne (First, Middle,	Maiden Suma	me)		
Maryland	Ment Ment arked	2	ADAM KURI	FK			FLIZ	ABETH	HALLI	VAR	Ζ	
lar	2 sho		19a. Informant's Name/Relationship (Ty	7		g Address (Street						
-	ges 1 and 2 should be filed within 72 hours after death with the Marylan It of Health and Mental Hygiene. If Item 27 is marked other than "naturel", or iteme 23a or 28a-f ehow or other traumatic event, the Medical Example and traumatic event, the Medical Example and the profiled at		REV. GERARDS ZYMKO	20b. Pla	6005.	CONKLI	NG ST, B	ALTIFIC	RE, M	ARYLI	ND 2112	4
Baltimore	ges 1 t of H If Ite or ot		20a. Method of Disposition 1 🗷 Burial 2 ☐ Cremation 3 ☐ P	temoval from State	netery, cren	natory or otner plac	(e)					
Ē	T to Ba		4 Donation 5 Other (Specify)	SACA	ED HE	ARTEFIE	SUSCEM JO	1244,2007	BALTIM	CREC	9, MARYLA	NL
Bal	permit. Departm Importer eny inju		21. Signature of Funeral Service Licens		22	Name and Address	EILER, 11	VC. FUNE	RAL H	OMES	State of the	
			Catherine	MI, beller	Do not ente	OIEAST	ERIV JOVE	BALTI	MORL	EMA	YLAND2 Approximate	1231
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final	ne caus on each line.	DO HOL BILL	or the mode or dyin	g, such as cordial	or respiratory arr	651,		Interval Between Onset and Deat	
	Physician /Medical		disease or condition resulting in death)	Pheumor								
	Examiner			Due to (or as a conseque	nce of):	•						
		ē	Sequentiatly list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	Dive to (or as a conseque	intia of):							
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	chamarie 2	en.46	Soile-	0					
oʻ	exec an an rial-tr		resulting in death) Last	Due to (or as a conseque	nce of):	0						
8760,	icate be executed physicien and s the burial-transit	Physician/Medical		d								
9	ng ph	Med	IF FEMALE:	`								
Вох	The law requires that the death certific tie has been signed by the attending p page 2 should be detached for use as	an/h	23b. Was decedent pregnant	3c. If yes, outcome of pregnand 1 Live birth 2 Fetal of		Ectopic pregnancy				ate of delive		
О. П	e dea the at	sici	in the past 12 months?  1 Yes 2 No	4☐ Pregnant at time of dea 9☐ Unknown		Other (specify)			М	onth	Day Year	
<u>Ч</u>	that the de led by the a detached	Phy	9 Unknown	stalle stage to death but and annual		4-4		22a Dida	h			2
ŝ	signe signe	þ	Part II. Other significant conditions con	ithouting to death but not result	ing in me ur	idenying cause giv	еп іл Рад І.		es 2□No	3 Prob	e cause of death ably 4 ⊖tinkn	
Orc	w requir been si should	etec										_
Vital Record	elaw hasl	Completed						24a. Was a autops perfor	sy	Were auto prior to cor death?	psy findings avai npletion of cause	abte of
a								1 ☐ Yes	2 1 No		2 1 No	
<b>\rightarrow</b>	Physician: The lar this certificate has ral director, page 2	Be	25. Was case referred to medical examiner?	lospital:		Oth	or.	ath Check only or				_
o	Attending Physician: r death. ector: After this certific by the funeral director,	1.70	1 ☐ Yes 2 ☑ No		R/Outpatien 28b. Time of	t 3□ DOA 28c. Injun Worl	4   Nursing F	lome 5 Resid			′)	
O	th. : Afte	tio	1 Naturat 5 Pending 2 Accident Investigation	(Month, Day Year)	Injury		k? Yes 2 □ No		, , , , , , , , , , , , , , , , , , , ,			
Division of	Attend r death ector: / by the f	ifica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At hom	ne, farm, stre	et, factory, office		28f Location (S		ber or Rura	l Route Number,	
á	in State	Certification;	4  Homicide determined	building, etc. (Specify)				City or Tow	n, State)			
	To the Hospital or Attending letthin 24 hours after death. To the Funeral Director: After campletely filled in by the funer	edical (	29a. Certifier 1 ☐ Certifying Physical (Check only one)	sician: To the best of my know ner: On the basis of examinationand manner stated.	ledge, death on and/or inv	occurred at the ting restigation, in my o	ne, date and place pinion, death occu	, and due to the corred at the time, d	ause(s) and m late and place,	anner as st	ated. the cause(s)	
	To th	Me	29b. Signature and title of certifier			29c. Licensi	e number	2	9d. Date signe	ed (Month,	Day, Year)	
			1 South NO	nurer MG	NEW	DOC	06509	4	6/30/	07		
í	$\gamma$		30. Name and address of person	pleted a use of death (Item 2					1			
Į	U		DE NOUVEN BING	MD 9000	FRAN	WLIN SO	PUARE D	R BALT	MORE	MD	21237	_
à	Sta	100000	31. Date filed (Month, Cay, Year)	32 Societrar's Signatu	re						-	
	Registr	ar	JUL 0 9 20	07 Begins B	La	We will						

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Mai		ertificate of		,	Reg. No. 2	7 2190;
8	Physici	an	1. Decedent's Name (First, Middle, L ${f Theodore} \ {f E}_{f ullet}$					2. Date of Dea	Day Yea	1120 C 2 AM
2.	/Medio		4a. Facility Name (If not institution, gi			4b. City, Town, o	or Location of Death	Jaca	2, 200 4c. County of D	
1	Lxaiiii	ici	Union Memorial H			Baltin	nore		N/A	
	Funeral Director		217-07-6152	Sex 7. Age ( 1 1 1	In yrs. last birthda 89 Yrs.	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da Dec. 12	th y, Year) 2,1917 M.	Birthplace (State or Foreign Country) aryland
	land ow tt		Usual Residence of Decedent  10a. State 10b. County	1	Oc. City, Town or	Location				10d. Inside City Limits
	Mary a-f sh	tor	MD N/A		Bal:	timore				1 X Yes 2 No
	th with the 23a or 28a ist be not	al Director	10e. Street and Number 810 Umbra Stre	et		10f. Zip Code	21224		10g. Citizen of What USA	Country?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status  1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates:	er in U.S. 13	3. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 🛣 No		pecify Yes or No o Rican, etc.)	14. Race - A Black, W Specify: W.	
1215-0	rithin 72 ho ne. han "natu e Medical	Completed	15. Decedent's l (Specify only highest g Elementary/Secondary (0-12)		(Gi	cedent's Usual Occup ve kind of work done on DO NOT use retire Electricia	during most of wor d)	king	16b. Kind of Busine  Bethleh	ss/Industry em Steel
Maryland 21215-0036	d be filed w ental Hygie ced other ti c event, th	Be	17. Father's Name (First, Middle, Las William Krepp	rt)			18. Mother's Nan	ne (First, Middle, chweiger	Maiden Surname)	
aryl	shoul ind Me s mark umati	ြ	19a. Informant's Name/Relationship	(Type. Print)	19b. Ma	iling Address (Street	and Number or Ru	ıral Route Numb	er, City or Town, State	e, Zip Code)
	and 2 ealth a n 27 ls		Genevieve Krepp-	Wife		Umbra Str	eet Balt			
Baltimore,	Pages 1 ment of H ant: If iter jury or oth		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3  4 ☐ Donation 5 ☐ Other (Special Content of the Content		Metro Ci	position (Name of rematory or other pla	7/3/			e, Maryland
Ball	permit Depart Import any in		21. Signature of Funeral Service Lic			6224 Easte	rn Avenu	e Baltim	Zeiler & nore, MD 2	
U			23a. Part1. Enter the disease of co shock, or heart failure. List on	mplications that caused the yone cause on each line.	ne death. Do not e	enter the mode of dyi	ng, such as cardiad	or respiratory a	rrest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		consequence of):	sepsis				one week
	Examiner			b.	consequence or).					
	p #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequence of):					
•	xecute and II-trans	Examiner	that initiated events resulting in death) Last	c Due to (or as a	consequence of):					
68760,	tificate be executed ig physician and as the burial-transit	edical E		d						
	rtificat ng phy as the		IF FEMALE:							
.O. Box	The law requires that the death certificate be executed the has been signed by the attending physician and use 2 should be detached for use as the burial-transit	Physician/IV	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	☐ Fetal death	3 □Ectopic pregnanc 5 □ Other <i>(specify)</i> _	у		23d. Date of Month	delivery Day Year
Δ.	luires that n signed by Id be deta	þ	Part II. Other significant conditions	contributing to death but	not resulting in the	underlying cause gi	ven in Part I.	23e. Did t		e to the cause of death?  Probably 4 (20)
Division or Vital Records,	has has	Completed						24a. Was autoj perfo 1□ Yes	an 24b. Were psy prior death	
ita	<i>(a</i> □	Be C	25. Was case referred to medical examiner?				26. Place of Dea		- 1	C3 2 2 110
ر ا	di is	은	1 ☐ Yes 212 No	Hospital: 1 Impatient 28a. Date of Injury		IGIT 3 DOX			dence 6 Other (S	Specify)
on (	Attending Prodesth.  ector: After by the funer	tion:	27. Manner of Death  1 Natural 5 Pending  2 Accident investigati	(Month, Day	Year) 28b. Time Injur	y Wo	rk? ]Yes 2∐No	28d. Describe	how injury occurred	
Divisi	ul or Atten after deat I Director d in by the	Certification:	3 Suicide 6 Could not determine	be 200 Place of injun	y - At home, farm, (Specify)	street, factory, office		28f. Location (		Rural Route Number,
	To the Hospital or Attending Ph within 24 hours after death.  To the Funeral Director: After th completely filled in by the funeral	Medical C	29a. Certifier (Check only one)  1 Certifying I	Physician: To the best of aminer: On the basis of e and manner state	examination and/or	eath occurred at the trinvestigation, in my	ime, date and place opinion, death occ	e, and due to the urred at the time,	cause(s) and manne date and place, and	r as stated. due to the cause(s)
	To the Within To the	Me	29b. Signature and title of certifier	,		29c. Licen	se number		29d. Date signed (M	onth, Day, Year)
	T		CARRETURA	minemare	MD	Do	06317	6	July 2,	2007
	10		30. Name and address of person wh	o completed cause of dea wachinemer	ath (Item 23a) (Typ	e, Print)	0010	21000	al, MI	
	Sta	ate	31. Date filed (Month, Day, Year)	2007 32 Registrar	's Signature	Logado D	DIN UNIS	nuspu	-(), ·() -	
	Regist	rar	JUL 0 9	LUUI JAGO	1 14° /9	The state of the s				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** June 30, 2007 7:38 p Helen C. Lazenby /Medical 4b. City, Town, or Location of Death Columbia 4c. County of Death Howard 4a. Facility Name (If not institution, give street and number) Examiner 6200 Cedar Lane If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Month Pay Year 29 Birthplace (State or Foreign County York 6. Sex **Funeral** 1 □ M 2 1 F 107.22.1928 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show Examiner must be notified at Columbia Maryland Howard Director 1 ☐ Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21044 'natural', or items 23a or 6200 Cedar Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Yo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ Mo Specify: þ White Specify: 3 ☐ Widowed 4 ☐ Divorced Completed permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical E once. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) federal government analyist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Gertrude Terpening Be August Raggenbass 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6200 Cedar Lane Columbia, Maryland 21044 Spouse Mr. William A. Lazenby 20b. Place of Disposition (Name of cemetery, crematory or other place)
Loudon Park 20a. Method of Disposition 20c. Location - City or Town, State Baltimore, Maryland 07/05/07 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State nation 5 Other (Specify) use of Fyrgeral Service License 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 MO0535 art1. Enter the diseas shock, or heart failur. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final sease or condition sulting in death) MeningHB **Physician** weeks /Medical Due to (or as a consequence of): Examiner Anop 284tc Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and s the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Certification: To Be Completed by Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 □Ectopic pregnancy Month Day Year 5 ☐ Other (specify) Division or Vital Records, P.O. 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 □Other (Specify) HOSPICE 5 M Residence nours after death.

Ineral Director: After this
y filled in by the funeral di 27. Manper of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) Medical completely 29c. License number 29b. Signature and title of certifier 000640 30. Name and address of person who completes cause of death (Item 23a) (Type, Print) Orteans 1550 JMMS HOLOMS
32 Registrar's Signature HOSPITCA 31. Date filed (Month, Day, State Ò 9 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month. Physician /Medical 4a. Facility Name (If not institution, give street and number) Town, or Location of Death 4c. County of Death Examiner Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 1 F 3 Director 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 28a-f show aţ 1 ⊈es 2 No be notified Director timore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code if and 2 should be filed within 72 hours after death with 1 Health and Mental Hygiene. iem 27 Is marked other than "natural", or items 23a or ? ISA must Funeral Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) traumatic event, the Medical Examiner Black, White, etc. 1 ☐ Yes 2 ■
If Yes, Give
Year or Dates: 1XNever Married 2 ☐ Married 2 No 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Yural Route Number, City or Town, item 27 4428 (40.14D21212 Ob. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 20a. Method of Disposition Important: If it any Injury or o Department of 1 Burial 2 □ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. ANCER Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off. Examiner law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 4☐Pregnant at time of death 9☐Unknown Dav 5 Other (specify) signed by the aid be detached f 1 ☐ Yes 2 ☐ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? or Vital Records, þ 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 □ No Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an has autopsy page ; this certificate To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3□ DOA 1 🔲 Inpatient P funeral 27. Mann of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Division (Month, Day Year) 5 ☐ Pending investigation 2 ☐ Accident 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: / 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

State Registrar

31. Date filed (Month, Day, Year) 0.9

29b. Signatule and title of certifier



nd address of person who completed cause of death (Item 23a) (Type, Print)

och Raven Avd . MT 601

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

			For State Registrar	State of M	-	-	rtment of H t <i>ificate of L</i>	ealth and M D <i>eath</i>	•	giene Reg. No.	1117	21000
F	Physici	an	1. Decedent's Name (First, Midd	ile, Last)			D 66:		2. Date of De Month		Year	3. Time of Death
E	/Medic	cal	Julia		F.	М	cDuffie	Location of Dooth	7	4	2007 County of Death	8:15p M
7	Examin	ier	4a. Facility Name (If not institution 1722 Abbots)	_			4b. City, Town, or Balt	timore		40.0	NA	
	Funeral Director		5. Social Security Number 218–58–6904	6. Sex 7. Ag	ge (In yrs. last bir 55	thday)_ Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 6-27	th l <i>y, Year)</i> 7–1952	Count	ace (State or Foreign try) Md.
	land ow at		Usual Residence of Decedent  10a. State 10b. Count	у	10c. City, Towr	n or Loc	ation				10	Od. Inside City Limits
	e Mary a-f sh iified a	ctor	Md.	NA	Bal	Ltim	ore					1 <b>X</b> Yes 2 ☐ No
	ith the or 28 se not	Director	10e. Street and Number				10f. Zip Code			10g. Citize	en of What Count	try?
	eath v is 23a must	Funeral	1722 Abbotsto	on Street 12. Was Decedent	Ever in U.S.	13 W		21218	ecify Ves or No	h 14	USA 4. Race - America	an Indian
920	3 within 72 hours after death with the Maryland Jene. r than "natural", or items 23a or 28a-f show the Medikal Examiner must be notified at	þ	1 □ Never Married 2 □ Ma  3 ☑ Widowed 4 □ Divorce	Armed Forces?  rried 1 Tyes 2 X  If Yes, Give			Yes, specify Cuba  ☐ Yes 2【XNo	spanic Origin? (Sp. n, Mexican, Puerto Specify:	Rican, etc.)		Black, White, e	
5-0	72 hc "natur dical	eted	15. Decede (Specify only high	nt's Education est grade completed)	16a.	Decede	ent's Usual Occupa	ation luring most of work )	ing	16b. Kind	d of Business/Ind	ustry
121	within iene. than "	Completed	Elementary/Secondary (0-12) 12th grade	College (1-4or	· ·		ployed	)		,	ΝΆ	
pq 5	e filec al Hyg othe rent,	Be C	17. Father's Name (First, Middle					18. Mother's Name		, Maiden S	Surname)	
ylaı	should be and Mental s marked o umatic eve	P	William	Dougl			and	Eloise			Knight	
Maryland 21215-0036	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		19a. Informant's Name/Relation Natasha McDi		I .			and Number or Run on Street				Code) 1218
Baltimore,	ges 1 ar It of Hea If item or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	2 □ Pamayal from State	comofoi	Dispos	ition (Name of atory or other place	e)	Date	20c. Loca	ation - City or To	wn, State
tim	Pages tment of I tant: If ite		Donation 5 ☐ Other (	Specify)			int Cem.	7-6-	-07	Balt	timore,	Mđ.
Bal	permit. Pag Department Important: I any Injury o		1. Signature of Funeral Service	e License	W		Name and Address	North	larch F.			21202
	Physician /Medical Examiner	ner	234 Flatt1. Enter the disease, shock, or heart failure. List the disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	a. Due to (or as	a consequence	S <sub>e</sub>	tumou	s Cell	C4	Ou	14t_	Approximate Interval Between Onset and Death
68760, <	ficate be executed groupsician and is the burial-transit	edical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of	of):						
.O. Box	eath certi attending for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death		Ectopic pregnancy Other (specify)			23	Bd. Date of deliver Month	ry Day Year
rds, P.	w requires that the d been signed by the should be detached	þ	Part II. Other significant condi	tions contributing to death b	out not resulting in	the un	derlying cause give	en in Part I.	23e. Did t	obacco use		e cause of death? ably 4 ∐Unknown
or Vital Records,	The lar	Completed							24a. Was auto perfo 1∐ Yes		prior to con death?	osy findings available inpletion of cause of
Zita Zita	Physician; Th this certificate ral director, pag	) Be	25. Was case referred to medic examiner?  1 Yes SHN0	al Hospital: 1 ☐ Inpati	ent 2 ☐ ER/Ou	tnationt	3□ DOA Othe	26. Place of Deat	1			Α.
٥٢	ig Physter this neral di	n: To	27. Manner of De	28a. Date of Inju	ıry 28b. 1	Time of njury	28c. Injury Work		28d. Describe		Other (Specify occurred	7
sior	tendin eath. tor: Af the fur	catio	1 Natural 5 Pend 2 Accident inves 3 Suicide 6 Could	tigation			M 1 1	res 2 □ No				
Division	afor At after d I Direc d in by	Certification:		mined   28e. Place of Inj	ury - At home, fa tc. (Specify)	rm, stre	et, factory, office		28f. Location ( City or To		Number or Rural	Route Number,
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	edical C	29a. Certifier (Check only one)	ing Physician: To the best Il Examiner: On the basis of and manner st	of examination an	e, death d/or inv	occurred at the timestigation, in my of	ne, date and place, pinion, death occur	and due to the red at the time,	cause(s) a date and p	and manner as standard due to	ated. the cause(s)
	To ti To ti comj	M	29b. Signature and title of certif		-		29c. License	number		29d. Date	signed (Month, L	Day, Year)
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	Sta	ite_	30. Name and address of persons 31. Date filed (Month, Day, Yea	n who completed cause of c	pleath (Item 23a) (	EE	Non	to Calu	at so	13-	stino	~ May
	Registr	ar	JUL 0 9	ZUU/ Marie	S P	pan						

Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2007 Day **Physician** 1110 am /Medical CALVIN CORNELIUS MADDOX 4a. Facility Name (If not institution, give street and number, 4c. County of Death Examiner General MRYland Baltimore NOSDI tal If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 6. Sex Birthplace (State or Foreign Country) **Funeral** 1**∑**M 2□F Director 213**-**26-9185 1-6-1929 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or Items 23a or 28a-f show Examiner must be notified at 1X Yes 2 □ No N/A Director MD. BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21231 Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.
Int: If Item 27 Is marked other than "natural", or Items 23 Funeral 104 N. BROADWAY APT 3 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: BLACK þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) -11-TRUCK DRIVER TRANSPORTATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be GEORGE E. MADDOX SR. AUGUSTA M. YOUNG ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Item 27 I 104 N. BROADWAY APT 3 BALTIMORE, MARYLAND 21231 HELEN MADDOX (WIFE) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If It any injury or o once, Burial 2 Cremation 3 R 3 Removal from State NEW CATHEDRAL CEMETERY 7-9-2007 BALTIMORE, MARYLAND 21. Signature of Thera Service License J NATHAN D. HIBNER Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part I Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of): Approximate Interval Between Onset and Death **Physician** ays /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed Exami physician and sthe burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes 2☑No the Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | 1 | No Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Matural Injury 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 3☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) asantha cumar. 42510

State

Registrar

821. N. EUTAWST # 407.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9 2007

Iceman

32 Registrar's Signature

M. VASAWTUA

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** MCG 2007 TUL /Medical County of Death Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner MORE COURS ON N/A If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthdav) 5. Social Security Number 6. Sex **Funeral** Months Days 1 ☐ M 2 🗓 F NORTH CAROLINA 5-18-1932 Director 215-06-5413 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits death with the Maryland 10a. State 10b. County 28a-f show must be notified at 1 DXYes 2 □ No BALTIMORE N/A MD. Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number ŏ Item 27 is marked other than "natural", or Items 23a other traumatic event, the M-dical Examiner must b 21223 USA 229 N. MOUNT ST. APT 111 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or Item 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Baltimore, Maryland 21215-0036 Specify: BLACK þ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) COSMETOLOGY BEAUTICIAN -0--10-17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ANNIE MAE MCPHATTER SPENCE McGIRT 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 58 W. 128th ST. APT 1 NEW YORK, NEW YORK 10027 JIMMY PERCELL(SON) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Dispo ition permit. Pages ' Department of H Important: If it any injury or o once. 3/ Removal from State 1 ☐ Burial 2 1 Cremation METRO CREMATORY 7-9-2007 BALTIMORE, MARYLAND 5 Other (Specify) 4 Donation D. HIBNER Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. ice Kicensee JONATHAN 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part1. In or the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, in heart failure. List only one cause on each line. Immediate Cau e (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Date for first as a compequence off Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23h. Was decedent pregnant 1 ☐Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) I□Yes 2□No the 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has 1□ Yes certificate 2 No Hospital or Attending Physician; 26. Place of Death Check onl one Be 25. Was case referred to medical examiner? Other: 4 Nursing Home Hospital: 1 Yes 2 No 3□ DOA 1 Ampatient 2 ER/Outpatient 5 ☐ Residence 6 ☐ Other (Specify) ဥ this 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury 27. Mannes of Leath Certification: After ! 1 Natural (Month, Day Year) Injury 5 Pending investigation 1 TYes 2 □No 2 Accident Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier

within 24 hours a

State Registrar

Medical

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

RLIZ 32. Registrar's Signature

30. Name and address of person who completed cause of death



(Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

D003035T

BON SECOURS

29d. Date signed (Month, Day, Year)

# MONTALBAND LOUIS CHARLES Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

		For State		State	of Ma	aryland		artment of F rtificate of I			lental Hy		and and	0.1.0.1.1
	<del>-</del>	Registrar     Decedent's Nan	me (First, Middle,	Last)				imouto or i	Death		2. Date of De	Reg. No.	444	3. Time of Death \( \rightarrow\)
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2 shou and M Is mai		19a. Informant's N	Name/Relationshi	p (Type. Print)				g Address (Street		er or Rura	al Route Numb	-		Code)
and 2		Sandy D		(Daug	hter			Longview	Ave.		sadena,		21122	
ages 1 nt of H iffite or ot			Cremation		m State	cen	netery, cren	sition (Name of natory or other place	i		ate		ion - City or T	,
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To the Hospital within 24 hours a To the Funeral I completely filled	edical	(Check only one)	2 ☐ Medical E	xaminer: On the	e basis of anner sta	examination	n and/or inv	vestigation, in my o	pinion, dea	ath occurr	ed at the time	date and pla	ace, and due t	o the cause(s)
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٤	-	30. Name and add	dress of person w	ho completed ca	ause of de	eath (Item 2)	3a) (Tvne 1	Print)	wlee	Cur	les b	<u>un 0</u>	7 -	Glen Burnie
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav Year Month **Physician** Barry 2007 Macon /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Mary land Baltimore 5. Social Security Number Medical Center 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 9. Birthplace (State or Foreign Funeral 1 **X**M 2 □ F 44-68-3488 Director North Carolina Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County 28a-f show must be notified at 1 Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number ō permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a any Injury or other traumatic event, the Medical Examiner must ano. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry dary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be 20a. Method of isposition 1 XBurial 2 □Cremation 0 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee KRd. Balto M lot 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line. ying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): **Physician** /Medical **Examiner** Due tylor as a consequence of the Sequentially list conditions, if any leading 1. In reduct cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 9□ Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Medical Certification: To Be Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1□ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 214 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 2 ☐ Accident filled in by the 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Greate St Freest, MD 31. Date filed (Month, Day, Year) State JUL 09

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year 345 NEAL AULINE JULI 2007 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) HOPKINS BAYVIEW MEDICAL CENTER BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number Days Hours Months 1 M X F MD JUNE 25 1930 214-26-6605 Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits 10a. State 10b. County DUNDALK BALTIMORE MD 1X Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21222 USA 107 CENTER STREET Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. ☐Yes 2 f Yes, Give 1 Never Married 2 Married Specify: BLACK 1 □ Yes 2 X No þ If Yes, Give Year or Dates: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DOMESTIC HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JAMES P. NEAL AGNES BLAND 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 626 NEW PITTSBURG AVE., TURNER STATION, MD 21222 MILDRED HEGGINS/SISTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 7/12/07 ESSEX, MD HOLLY HILLS MEM PK 4 ☐ Donation 5 ☐ Other (Specify) 21. Ignat re of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC 1701 LAURENS ST., BALTO., MD 21217 Approximate Interval Between Onset and Death 23a Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final KESPIRATORY HOURS disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ISCHEMIC VAG.81 COLITIS Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 ☐ Other (specify) 4□Pregnant at time of death 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 12 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 TYes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 🗆 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide

1 🗘 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

.000

29d. Date signed (Month, Day, Year)

BALTIMORE

MD 21224

requires that the death certificate be executed Box 68760, P.0.

**Physician** 

/Medical

Examiner

**Funeral** 

Director

iral", or items 23a or 28a-f show Exaπiner must be notified at

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or other

Injury (

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**Physician** 

/Medical

Examiner

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page 2 should

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After this

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permit. Pages 1 and 2 Department of Health a Important: If item 27 is

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Division or Vital Records, tal or Attending Post after death.

al Director: After the fin by the funers

filled in by To the Hospital c within 24 hours af To the Funeral D

State Registrar

Medical

(Check only

29b. Signature and title of certifier

E/1ZABETH

31. Date filed (Month, Day, Year) JUL 0 9 2007



and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

			1 - State of Mar Registrar		riment of Heatificate of De			gierie Reg. No.	1007	21914
	Physicia	an	1. Decedent's Name (First, Middle, Last)				Date of Dea     Month	Day	Year	3. Time of Death
	/Medic	_	Doris M. Pumphrey		# 02 T		July	-,	2007	9:40 P. M
	Examin	er	4a. Facility Name (If not institution, give street and number)  6 Normandy Drive		4b. City, Town, or Lo				County of Death Anne Ar	
	Funeral			In yrs. last birthday)	If Under 1 Year	f Under 24 Hrs.	8. Date of Birt	h		nplace (State or Foreign
5	Director		216-20-1890 ¹□M 2XX¥	78 Yrs.	Months Days	Hours Min.	Aug. 15	, rear)	28 Mary	land
7	how at		Usual Residence of Decedent  10a. State 10b. County 1	0c. City, Town or Loc	cation					10d. Inside City Limits
	a-f s	Director	Maryland Anne Arundel	Glen Bu	T					1 ☐ Yes 🏄 No
1	or 28	Dire	10e. Street and Number		10f. Zip Code				en of What Cou	
	is 23e	eral	6 Normandy Drive	erin IIS 13 V	21060	nanic Orlgin? (Sne	cify Yes or No		ed Stat	
0000	The Winter in 7 mous are bean with the maryand that Hygiene than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  1 □ Never Married 2 □ Married  1 □ Never Married 2 □ Married  1 □ Yes 2 □ No If Yes, Give Year or Dates:		Vas Decedent of Hisp Yes, specity Cuban, ☐ Yes <b>XX</b> No	Mexican, Puerto I Specify:	Rican, etc.)		Black, White	
ה ה	"natura edical E	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	ent's Usual Occupation  kind of work done dur  OO NOT use retired)	on ring most of working	ng	16b. Kin	d of Business/I	ndustry
7 .	iene. rthan the M	ошо	Elementary/Secondary (0-12) College (1-4or 5+)	1	il Sales			Dep	artment	Store
		BeC	17. Father's Name (First, Middle, Last)		18	8. Mother's Name			Surname)	
<u> </u>	Menta Menta arked atic e	일	Howard Collison				ia Eidn			
Mar	permit. Tages 1 and 2 should be lied whitin Department of Health and Mental Hygiene. Important: If item 27 is marked other than "I any injury or other traumatic event, the Med once.		19a. Informant's Name/Relationship (Type. Print) Robert Pumphrey / Son		g Address (Street and cmandy Dri					ip Code)
Daltimore	ent of He ent of He at: If item y or oth		20a. Method of Disposition  1 □ Burial 2 □ □ Cremation 3 □ Removal from State  4 □ Donation 5 □ Other (Specify)	20b. Place of Dispos cemetery, crem Metro Cre	sition (Name of natory or other place)	July 200			cation - City or 1	
Daliti	Departm Departm Importar any inju		21. Signature of Funeral Service Licensee		Name and Address kley-Rudd	of Facility ick Fune	ral Hon			261
			23a, Part1. Enter the disease, or com stations that caused the shock, or heart failure. List only ofe cause on each line.	42] e death. Do not ente	er the mode of dying,	such as cardiac o	or respiratory a	ırnie rrest,	, MD 21	Approximate Interval Between Onset and Death
	hysician /Medical	Ε	disease or condition a. Znd 310	con equence of):	enal o	uspase	9			Gmoth-
	Examiner	<u>_</u>	Sequentially list conditions,	consequence of):					(1)	years.
]	ned	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events						Ĭ	1 year
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00/00	incate be executed g physician and as the burial-transit	edical	d							
O. DOX 0	w requires that the death certific been signed by the attending p should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 2 1 1	☐ Fetal death 3☐	Ectopic pregnancy Other (specify)			2	3d. Date of deli Month	very Day Year
as, r.	signed by	by	Part II. Other significant conditions contributing to death but	not resulting in the un	nderlying cause given	in Part I.	23e. Did t		se contribute to	the cause of death?
13	ne law req e has been age 2 shou	Completed						psy ormed?	prior to death?	topsy findings available completion of cause of
<u>ra</u>	an; r tificat tor, pa	Be Co	25. Was case referred to medical		2	26. Place of Death	1  Yes ∩ (Check only o	2 No one)	1 ☐ Yes	2 No
2	nysici nis cel direc	To B	examiner? 1 ☐ Yes 27 No Hospital: 1 ☐ Inpatient	2 ER/Outpatien	t 3 DOA Other:	4 ☐ Nursing Ho	me 5 Resi	dence 6	i □Other (Spec	cify)
0 1	Ing Pr		27. Manner of Death 28a. Date of Injury 1 Natural 5 Pending (Month, Day )	(ear) 28b. Time of Injury	Work?		28d. Describe	how injury	occurred .	
IVISION	of the nospital of Attending Priysician; The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Certification:	I Accident     investigation       3 Suicide     6 Could not be determined       4 Homicide     determined       28e. Place of injury building, etc.	r - At home, farm, stre (Specify)		es 2 No	28f. Location (S City or Tou			ral Route Number,
ב	hours at uneral D		29a. Certifier (Check only 2   Medical Examiner: On the basis of e							
	thin 24 the F the F mplete	Medical	one) and manner state		29c. License n				e signed (Month	
	× 3 × 8	-	200-4	wician.						
•	1		30. Name and address of person who completed cause of dea	fin (ftern 23a) (Type,	- 17	110		,,,	J	
N	)		GURMEET S. SAWHNEY	e MD,	325 Hos	PITAL.	DRIVE	SLIT	202	don Benzo
t	Sta Registr		30. Name and address of person who completed cause of dea  GURMFET S SAW HVES  31. Date filed (Month, Day, Year)  32. Redistrar	s Signature	foots					21061.

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5601 LOCH RAVEN BLV1 BALTIMONE MY 2118 32. Redistrar's Signature

200

07-05077 K

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

aleigh Price	State of Maryland / Departn 1- For State Certific	nent of Health and Mental F cate of Death	lygiene Reg. No	o. 2017	
Physician Medical Examine	Decedent's Name (First, Middle,Last)		2. Date of Death  Month Day	Voor	e of Death 40 hrs
The state of the s	4a. Facility Name (if not institution, give street and number) Harford Memorial Hospital	4b. City, Town, or Location of Dea Belair		4c. County of Death Harford	
Funeral Director	5. Social Security Number 6. Sex 1 7. Age (In yrs. last b	irthday) If Under 1 Year If Under 24H Months Days Hours Mi		Foreign	(State or Maryland
w any	Usual Residence of Decedent  10a. State	n or Location cettsville			nside City Limits Yes 2 No
with the Maryland in 23a or 28a-f show be notified at once.		10f. Zip Code 21084	10g. C	itizen of What Country?	res 2 No
or items 23a or 28a-f shurust be notified at once		13. Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Puer		14. Race - American Ind White, etc.	lian, Black,
8 7 D N		1 Yes 2 No specify:	work done 16b	Specify: White	,
5-0036 led within 72 hours after the within 72 hours after the within 72 hours after the wither than "natural" the Medical Examine Committeed by	Elementary/Secondary (0-12) College (1-4 or 5+) N/A N/A	during most of working life. DO NOT use re $N/A$	etired)	N/A	222
21 be fi rked rked	David W. Workman	Casey	ne (First, Middle, Maide Leigh Price	e	
MD 21 ad 2 should lith and Me an 27 is ma aumatic ev	Casey Leigh Price-Mother	9b. Mailing Address (Street and Number of 4088 Madonna Rd. Jar	rettsville	, MD 21084	
Baltimore, MD 2 permit. Pages 1 and 2 shou Department of Health and 1 Important: If item 27 is 1 injury or other traumatic.	1 X Burial 2 Cremation 3 Removal from State crem 4 Donation 5 Qther Spacify:	ora manoriar	7/2007 A	Location - City or Town,	
Bał permi Depar Impo injury	21. Signature of Mineral Service Ulcensee	22. Name and Address of Facility   3 Newport Drive Forest	HILL, MD ZIC	)50	æl Air
Physician Alvadical Yaminer	23a. Part I. Enter the disease, or constitutions that caused the death. Do failure. List only one cause on each limit.  Immediate Cause (Final disease or condition resulting in death)		or respiratory arrest, s		roximate Interval ween Onset and Death
,	Sequentially list conditions.				
led Insit	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C.  Due to (or as a consequence of):  Lue to (or as a consequence of).				
b0,  le be executed ysician and burial - transit	d.  AMENDED AMENDED 27 2007	1 0/15/07 TW	· · · · · · · · · · · · · · · · · · ·		
eath certificate attending phecicion	JX UNPENDED  AMENDED  #25a,27,perME,887  #25a,27,pe			3d. Date of delivery  Month Day	Year
P,O. B res that the d bigmed by the be detached		ing in the underlying cause given in Part I.		o use contribute to the cau	
of Vital Records, P.( g Physician: The law requires tha ther this certificate has been signed neral director, page 2 should be det			24a. Was an autopsy performed′		
Vital Rec ysician: The his certificate director, page	25. Was case referred to medical examiner?	26.Place of Death (Chec Outpatient 3 DOA Other,4 Nurs		dence 6 Other:	
on of \ ending Pln eath. or: After the funeral	27 Manner of Dooth 200 Date of Injury 201	28c. Injury at Work?  1 Yes 2 No	28d. Describe how in	njury occurred	
10 2 0 t 5 1	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)	farm, street, factory, office building, etc.	28f. Location (Street or Town, State)	t and Number or Rural Rou	ite Number, City
Divis  To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	29a Centiler		, ,		e(s)
	29b. Signature and title of certified	29c. License number O.C.M.E.		d. Date signed (Month, Date signed (Month) (Month, Date signed (Month)	y,Year)
		) 111 Penn Street, Baltimore, MD 2	21201		
Stat Registra	Address of the second s	Secret .			
DHMH 17 Rev 1/200	0	RICINAL	0045	<del></del>	

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** PERRII 2007. HENRY /Medical D 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** NORTHWEST HOSPITAL CENTER RANDALLSTOWN BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days 1 M 2 □ F 055-09-0653 89 05/25/1918 **Director** NY Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 1 ☐Yes 2 ☐ No Director BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? a or 1840 REISTERSTOWN ROAD #303 21208 "natural", or items 23a U.S.A. Pages 1 and 2 should be filed within 72 hours after death Funeral Was Decedent Ever in U.S. Armed Forces? Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 Yes 2 □ No If Yes, Give Year or Dates: WHITE 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 þ 3 Widowed 4 Divorced Completed permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) OWNER 4 INSTALLMENT SALES 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MORRIS **PERRIL** JENNIE FALAVITCH ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MILDRED PERRIL / WIFE 1840 REISTERSTOWN ROAD #303 -BALTIMORE, MD 21208 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CEDAR PARK 07/06/2007 PARAMUS, NJ 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Most Leuha 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician BALTEREMIA AUKEUS STAPHYLD LD ELUS /Medical Due to (or a a consequence of): Examiner SIFFI LILLE LOSTBIDIUM cause thaily not conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed BLUJE MCI Due to (or as a consequence of): physician at s the burial-t Division or Vital Records, P.O. Box 68760 Physician/Medical as attending properties for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4□Pregnant at time of death 9∏Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ATRIM FIBRILLATION 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 1 No GASTRO INTESTINA 24a. Was an autopsy performed? Ves 2 No 1as certificate ha 1☐ Yes After this certific funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Dotth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

. 2

State Registrar MIRTHWEST

31. Date filed (Month, Day, Year)

JUL 0 9 2007

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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PITHL

Registrar's Signature

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MEMTA

RAMOAUS TOWN MO

2007.

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month 1424 PM PAVLOVICH STEPITEN JULY 03 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JOHNS HOPKINS BAYVIEW MEDICAL CENTER BALTIMORE 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Date of Birth (Month, Day, Year) Months Days Hours Min. 218-60-5132 Director 28,1951 Maryland Nov. Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10b County r 28a-f show notifled at 10d. Inside City Limits 1 ☐ Yes 2 No Directo Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? of Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or other traumatic event, the Medical Examiner must be not the traumatic event, the Medical Examiner must be not the traumatic event, the Medical Examiner must be not the traumatic event, the Medical Examiner must be not the traumatic event, the Medical Examiner must be not the traumatic event. Funeral 7803 Lockwood Road 21222 United States 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2₽ No Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ Specify Specify 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Material Handler Manufacturing 12 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Rabenau Paul Pavlovich ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7803 Lockwood Road Dundalk, Maryland Cheryl Malczenski (Sister) Pages 1. ent of Hea 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any Injury or Injury or 7/6/2007 Towson, Maryland Sonation 5 ☐ Other (Specify) Hilltop Service Corp. 21. Sigr nature of Funeral Service Licen 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 Port . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** HYPOTENSION DAY /Medical Due to (or as a consequence of): **Examiner** HEMORRHAGE Sequentially list conditions Examiner fram, leading to ministrate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-transi LIVERFAILURE Due to (or as a consequence of): physician Physician/Medical the as IF FEMALE nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No autopsy perform 1∐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident (Month, Day Year) 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) . Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Division or Vital Records, P.O. Box 68760, the Hospital or Attending Physician: within 24 hours after To the Funeral Dire

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 EASTERN AVENUE BALTIMORE MD 2124 MARSH M.D. TH 32 Registrar's Signature State Registrar

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

JULY 03, 2007

Medical

(Check only one)

29b. Signature and title of certifier

Walt B. Marse

Nathaniel Price Tr.
07-05053 Pleas

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

JNK UNK		- For State	State	e of Marylaı		artment of ertificate of		and M	ental F		Reg. No.	1117	0.01
Physician Medical Examine	1	1. Decedent's Na	me (First, Middle,L	Price,	Ir.			٠	631 s	2. Date of De Month July 2, 2	eath Day Year	3. Time o	
			(if not institution, g	give street and nun	nber)		4b. City, Tow Baltimo		tion of Deat		4c. County of	Peath A	
Funeral Director		5. Social Security 24.13	· 6688 1	Sex 2 F	7. Age (In yrs.	last birthday) 30 Yrs	If Under 1 Months		Under 24Hr lours Mir		F 1976	9. Birthplace (S Foreign Country)	
Aaryland 28a-f show any 1 at once.		Usual Residence 10a. State	10b. County	/4	10c. City	y, Town or Locat Ba 1 th		ر.			·	10d. Insid	de City Limits
th the Maryland 23a or 28a-f sho notified at once	חוברו	10e. Street and N	lindem Vindem	ore Av	lenue	,	10f. Zip Co	212	18	10	10g. Citizen of Wha		
hours after death with the Maryland natural", or items 23a or 28a-f she Examiner must be notified at once	y - uilciai	11. Marital Status 1 Never Mar 3 Widowed	ried 2 Marri	12. Was Dece Armed For 1 Yes ed If Yes, Give Yeer			es, specify C		tican, Puert	Specify Yes or No Rican, etc.)	Io- 14. Race - White, Specify:	American Indiar etc.	
2 1 2 7	i bicica n	Elementary/Se	Education (Specify condary (0-12)	only highest grade College (1-		16a. Deceden during m	ost of workin	cupation (Gg life, DO I	NOT use re	work done tired)	16b. Kind of Busi	,	ent.
21 21 be fill rked ent,	3	Natha	(First, Middle, La	rice; Si	^.			18.Mc	other's Nam	RE.	, Maiden Surriame)	ე	
MD and 2 sho salth and 2 sho em 27 is raumati	L	19a. Informant's I Nathur 20a. Method of D	Name/Relationship	(Type, Print)	Father	19b. Mailing	Wir	Street and	Number or	Rural Route Nu AVLNU:	umber, City or Town, e Balto	State, Zip Code	218
Baltimore, N permit. Pages I and Department of Health Important: If item injury or other trau		1 Burial 2 4 Donation	Cremation	ify:	m State	crematory or oth	ner place)	meta	n 07/			ile, M.	
Balt Depart Import injury	-	V aug 23a. Part I. Enter	the disease, or cor	full polications that car	used the deat	40	105 Y	ork 1	Gad	Balta	GYLENE M More M rrest, shock, or hear	0 421	2 mate Interval
/Medical Examiner	ł	failure. List of Immediate Cause or condition resul	only one cause on (Final disease	each line. a. Sharp Force Due to (or as a c	Injuries							Betwee	en Onset and Death
ted J ansit		Sequentially list of any, leading to cause. Enter United Sease or injury	immediate derlying Cause	bbue to (or as a c									
50, tte be executed sysician and e burial - transit		events resulting i		Due to (or as a d	consequence (	of):							
Box 68760, c death certificate be executhe attending physician and of or use as the burial - transcription of the second of the		F FEMALE: 3b. Was deceder past 12 month	nt pregnant in the	23c. If yes, ou			tal death	3Ec	topic pregn	ancy	23d. Date of d	elivery Day	Year
). Box 6876: the death certifica by the attending phace of the or use as the		1 Yes 2	No 9 Unknownificant conditions	wn 9 death Unknov		5 Oti	ner (Specify)		n Port I	23a Did	tobacco use contrib	uto to the course	of dooth?
ords, P.O.  requires that the the the signed by reduced by lead of the detach to Dilleted by Dilleted by Dilleted by Dilleted by Dilleted by Dilleted by Dilleted by Dilleted by Dilleted by Dilleted by Dilleted by Dilleted	2							use given i			es 2 🗸 No 3		Unknown
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n of Vital I ding Physician: . After this certifi funeral director,		examiner?  1 Yes  27. Manner of De	2 No	Hospital: 1 In	patient 2	ER/Outpatient	3 DOA	Othor	T INUISII	ng Home 5	Residence 6 🗸		
Division or Attending urs after death.  ral Director: After of the function of the function of the function or fifter at one or fifter at one.		1 Natural 2 Accident	5 Pending Investiga	FOUND: Jul 2, 200	Day,Year)	FOUND: 1140 hrs	1	Yes 2	<b>✓</b> No	Subject sta			Number City
Division  To the Hospital or Attention within 24 hours after death To the Funeral Director: completely filled in by the	1	Suicide  Homicide  Suicide  Check only	6 Could no determin	ed (Specify)	Found in t	he car				or Town, rear of 4900		, Baltimore, M	
To the Hos within 24 h To the Fur completely	2	2 29b. Signature an	Medical Examin	er:On the basis of and manner sta	examination a	and/or investigat	ion, in my opi	inion, deatl	h occur <b>red</b> a	at the time, date	and place, and due	e to the cause(s)	
7	3	Calc.	ress of person who	o completed cause	of death (Item	n 23a)	0	.C.M.E.			July 3, 2007	,	
5 State		Zabiullah A	nth, Day, Year)	sistant Medica	l Examiner	r 111 Peni	n Street, E	Baltimore	e, MD 21	201			
Registra			JUL 09	2007	Belie	ure J. A	Sept.						

DHMH 17 Rev 1/2001 OCME 2006 07-05038 Sean Phelps

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

n Phelps		1- For State	State	of Maryla		artment of ertificate of		and Men	ntal Hyg	giene Reg.	No			9
Physicia	an/	1. Decedent's Name (First	, Middle Las	- 1					2.	Date of Death	ay Yea		3. Time of Death	٦
dical Exami	ner	4a. Facility Name (if not in	estitution giv	nelp	) <u>S</u>		b. City, Town	or Location		July 2, 2007	4c. County o		0129 hrs	4
		Johns Hopkins B				[	Baltimore		or Death		4c. County o	Death		
Funeral		5. Social Security Number	6. Se	ex	7. Age (In yrs.	last birthday)	If Under 1		$\overline{}$	8. Date of Birth(I	MM/DD/YYYY)	9. Birth Foreign	place (State or	$\neg$
Director		212-80-90	22 12	M 2 F	4	Yrs.	Months [	Days Hour	s Min.	8-9-	65	Cou		
any		Usual Residence of Deced 10a, State 10b, C		-	10c. Cit	y, Town or Location	on						10d. Inside City Limits	s
<b>*</b>	_	MD	,		T	asar	deno	<b>3</b> /					1 Yes 2	0
/arylar 28a-f s 1 at on	Director	10e. Street and Number		- 0			10f. Zip Cod	e		10g.	Citizen of Wh	at Count	ry?	$\dashv$
15-0036 filed within 72 hours after death with the Maryland filed within 72 hours after death with the Maryland I Hygiene.  d other than "natural", or items 23a or 28a-f show i, the Medical Examiner must be notified at once.	ä	<u> 7824 H</u>	utt	· (0)	wt		2.1	12:	2		US	A		_
ath wi items	neral	<ul><li>11. Marital Status</li><li>1 Never Married 2</li></ul>	Married	Armed Fo	cedent Ever in to		s Decedent of es, specify Cu			cify Yes or No- can, etc.)	14. Race White		an Indian, Black,	
nfler de al", or	by Fune	3 Widowed 4	Divorced	1 Yes	2 No	1	Yes 2	No specify	r:		Specify:	B	lack.	
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hin 72 e. than "	plet	Elementary/Secondary	(0-12)	College (1	-4 or 5+)	Tru	CKT	Driv	0 -		Prod	SIV	er	
5-0036 led within 7 Hygiene. other than	Completed	17. Father's Name (First,	Middle, Last)	199	<u></u>	114		18.Mothe	er's Name (F	irst, Middle, Mai	den Surn me)	3	roices	$\dashv$
21215-003 uld be filed withi Mental Hygiene. marked other ti e event, the Med	Be	Paul Pl	relp	S				$\perp \iota$		NOWA				
O 등 5 1 1 1 1	2	19a. Informant's Name/Re	lationship (T	ype, Print )	1 2:E	19b. Mailing	Address (S	treet and Nu	mber or Rur	ral Route Numbe		n, State,	Zip Code)	
ore, MI ss 1 and 2 s of Health a If item 27 her traum	30.217	20a. Method of Disposition		aps (		. Place of Disposi		cemetery,			20c. Location -	City or 7	own, State	
MOTE Pages 1 ent of H unt: If i		_	emation 3 ther Specify.	Removal fr	om State	crematory or oth	. 0	pmato	KJ 7	16/01	Pal.	to./	GM	
Baltimore permit. Pages 1 a Department of He Important: If it		21. Sanature of Funeral S	Service Licer	see	50 111	22	ame and Add	ress of Facili	25	weral	Serv	rce		_
		23a. Part I. En er the dise	Just,		DD944	th. Do not enter th	e mode of dv	Ba such as	Him.	on St	- Bac	<u>√</u>	Approximate Interva	_
Physician /Medical		failure. List only one	cause on e			an bo not onto: a		ing, coon do	00. 100 0. 1	oophatory all oot	, oneon, or nec		Between Onset and Death	
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scuted and transit		events resulting in death)	Last d.	Due to (or as a	consequence	Of):								
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Sox 68760, leath certificate be e e attending physicia for use as the buria		IF FEMALE: 23b. Was decedent pregna	ant in the	-	outcome of pre			2 75-1			23d. Date of		Veer	
x 68 h certif tending	ician/Me	past 12 months?		1 - 4	nant at time of		al death ner (Specify)	3Ectop	oic pregnanc	ЗУ	Month	D	ay Year	
Box ne death or the atten hed for us	hys	1 Yes 2 No 9		9 Olikik	own									_
Division of Vital Records, P.O. Box 68760 Hospital or Attending Physician: The law requires that the death certificate 24 hours after death. Funeral Director: After this certificate has been signed by the attending physicity filled in by the funeral director, page 2 should be detached for use as the b	by P	Part II. Other significant	conditions	contributing to	o death but not	resulting in the u	nderlying cau	se given in F	aπ I.				he cause of death? ably 4 Unknown	ı
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	al C	29a. Certifier 1 Certif				edge, death occur								
To the Hos within 24 h To the Fur completely	fedical			On the basis and manner s		and/or investigati								
	Σ	29b. Signature and title of	certifier	13				ense numbe C.M.E.	1		29d. Date signo July 3, 200		ui, ∪ay, rear)	
.,~		30. Name and address of	person who	completed care	e of death (Ite	m 23a)					2., 0, 200			
2		Zabiullah Ali, M.I		stant Medic	al Examine	er 111 Pen	n Street, B	altimore,	MD 2120	01				
S	ate	31. Date filed (Month, Day	r, Year)		egistrar's Signa	iture La	de.							

DHMH 17 Rev 1/2001

ORIGINAL

OCME

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month am 200 JOHN POOLE /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Deat 4c. County of Death Examiner HOSPI tal Jany/and Greneral Baltimore If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** Months Davs Min. XXM 2□F Hours Director 216 32 6641 67 AUG. 20,1939 MARYLAND Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show notified MD. N/A BALTIMORE 1 Nes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than "naturar", or Items 23a or any Injury or other traumatic event, the Medical Examiner must be in 501 FRANKLIN ST. 21201 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No Never Married 2☐ Married 1 ☐ Yes 2 ☐ No Specify:BLACK þ 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11TH UNKNOWN UNKNOWN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MORRIS POOLE LILLIAN ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LUCINDA SAUNDERS (cousin) 1316 N. LINWOOD AVE. BALTO, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) JULY 9,2007 GREEN MOUNT CEMETERY BALTIMORE, MD. innature of Funeral Service License CALVIN B. SCRUGGS FUNERAL HOME 1412 PRESTON ST. BALTO, MD. E 21213 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 05/3 /Medical Examiner microbial Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician a for use as the burial-Box 68760 Physician/Medical IF FEMALE If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 □Ectopic pregnancy in the past 12 months? Month Day 5 ☐ Other (specify) ed by the a Division or Vital Records, P.O. 9□ Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🗌 No 3 Probably 4 Honknown has been sign 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No page certificate or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 21 No P 1/2 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 5 Pending investigation 1 Natural (Month, Day Year) Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 🗹 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

within 24 hours after death

To the Funeral Director:
completely filled in by the 1 To the Hospital

> 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) aryland Greneral 31. Date filed (Month, Day, Year) State Registrar 0

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year)

0 9 2007

Danna M. Peloquin, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joanna M. Peloquin, MD. 600 North Wolfe Street, Baltimore, MD 21287 32. Redistrar's Signature

RES-000

July 5, 2007

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Month SA LLY A. RILEY 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HONARD WUNTY GENERAL INDSPITAL CownsIA If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Date of Birth (Month, Day, **Funeral** 1 ☐ M 2 🔀 F Months Days 205.18.9781 80 Director February 24, 1927 Pennsylvania Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ed other than "natural", or items 23a or 28a-f showevent, the Medical Examiner must be notified at Maryland Howard Ellicott City 1 ☐ Yes 2 ☑ No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21042 2922 Southview Road U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) health care registered nurse rmit. Pages 1 and 2 should be filed w partment of Health and Mental Hygier portant: If Item 27 Is marked other the y Injury or other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas A. Prim Mary Murphy ၀ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2922 Southview Road Ellicott City, Maryland 21042 Mr. John M. Rilev Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 □ Şurial 2 □ Cremation 3 □ Removal from State Marriottsville, Maryland permit. Page Department o Important: If any Injury or 07/07/07 Crest Lawn Memorial Gardens 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign ture 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 of Fur al Service License 1100531 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death iate Cause (Final ase or condition ulting in death) **Physician** SEPTIC SHOZIC /Medical Due to (or as a consequence of): Examiner PMEUMONIA BAUTERIM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed the burial-trar and Due to (or as a consequence of) Division or Vital Records. P.O. Box 68760. physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Day 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown MEMIA 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2☒ No Pulmontry 24a. Was an autopsy 2 X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital No Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) JULY 3 2007

67

State Registrar 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



DAVID O. NYANTOM MD. 18724 LITTLE PATURENT PARKWAY

fparti

21544

COLUMBIA MO

			1 - Stete Stete Registrar	of Maryland / Dep	partment of Healt ertificate of Dea		Hygier Reg. r		192.
	q		Decedent's Name (First, Middle, Last)			2. Date	of Death		3. Time of Death
	Physicia /Medic		Flore	ence Evelyn R	ichmond	Ju]		Day Year 2007	12:45P M
	Examin		4a. Facility Name (If not institution, give street and n		4b. City, Town, or Locati	ion of Death		4c. County of Deat	
			Riverview Nursing Hor		Essex				more Co.
H	Funeral		5. Social Security Number 6. Sex 1 ☐ M 2 ☑ F	7. Age (In yrs. last birthda	y) If Under 1 Year If Un Months Days Hou	irs Min. (Mon	of Birth th, Day, Yea	ar) Co	hplace (State or Foreign buntry)
	Director		214-50-7164 Usual Residence of Decedent	88 115.		Jur	ne 9,1	919   We	st Virginia
	yland		10a. State 10b. County	10c. City, Town or	Location				10d. Inside City Limits
	a-fst	tor	Maryland Baltimore	9	Du	ındalk			1 ☐ Yes 21 No
	or 28	Director	10e. Street and Number		10f. Zip Code		10g. (	Citizen of What Co	ountry?
	ath w	ral	2938 Yorkway		21222			ited Sta	
	er de Items	Funeral	Armed I	Forces?	<ol> <li>Was Decedent of Hispanic If Yes, specify Cuban, Mex</li> </ol>	c Origin? (Specify Yes xican, Puerto Rican, et	or No-	14. Race - Ame Black, Whit	
36	irs aft	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes (1)  3 ☐ Wildowed 4 ☐ Divorced Year or	Z <b>∕C</b> No Give Dates:	1 ☐ Yes 🎎 No Spec	ecify:		Specify:	White
Ö	2 hou	ted	15. Decedent's Education	16a. Dec	cedent's Usual Occupation		16b.	Kind of Business/	
215	e. en "n	ple	(Specify only highest grade completed Elementary/Secondary (0-12)  College	(Gr (1-40r 5+)	ve kind of work done during i . DO NOT use retired)	most of working			
7	ed will ygien ygien ter th	Completed	8 Years		Matron			olice De	partment
nd	be fill ttal H d oth	Be	17. Father's Name (First, Middle, Last)			fother's Name (First, A		len Sumame)	
7	d Mer narke natic	င္	Grayson Bragg  19a. Informant's Name/Relationship (Type, Print)	10h Ma	iling Address (Street and Nu	Adeline Sm		Taura Cana	Tin Code)
Maryland 21215-0036	d 2 si th an th an 17 is r		Tinford C Dichmond		7 Perth Lane			23150	up Code)
ē,	Heal Heal tem 2		20a. Method of Disposition	20b. Place of Dis	position (Name of	Date	20c.	Location - City or	Town, State
OE I	Pages ent of nt: If i		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from 14 ☐ Donation 5 ☐ Other (Specify)	n State	iematory`or other place) ill Mem. Gdns	7/7/2007	М	iddle Ri	ver. MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Inportent: If item 27 is marked other then "neturel", or items 23a or 28a-1 show any finduty or other treumatic event. Ite Medical Exercitivat meat be notified at once.		21. Signature of Funeral Service Licensee		22. Name and Address of Fa Duda-Ruck Fun				· · · · · · · · · · · · · · · · · · ·
<u> </u>	e e E E E	<b>b</b>	July a Jones		922 Wise Ave	. Dundalk	Mary	pland 212	222
г			23a. ant1. Enter the disease of complications that shock, or heart failure, it is only one cause or	caused the death. Do not e each line.	nter the mode of dying, such	h as cardiac or respira	tory arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	OROHAR?	* ARTER	P DISE	ASE		Onset and Death
	/Medical Examiner		Due t	o (or as a consequence of):	* 161				
		ē		o (or as a consequence of):	MELLIT	100		000	
\$.	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	NEGLIN	E HEAR	TFA	1110	RE	
oʻ	exec an an rial-tr	Еха		o (or a a consequence of):			I WAS		
8760,	icate be executed physician and s the burial-transit	dlcal	d						
9	ing pt	Med	IF FEMALE:	. maria manus					
Вох	leath certific attending pl	lan/	23b. Was decedent pregnant 1 Live		Ectopic pregnancy			23d. Date of del Month	ivery Day Year
0	the the	Physiclan/Me	1 ☐ Yes 2 ☐ No 4☐ Pre 9 ☐ Unknown 9☐ Unk		i ☐ Other (specify)		_		
<u>a</u>	that the	y Ph	Part II. Other significant conditions contributing to	death but not resulting in the	underlying cause given in P	art I. 23e.	Did tobacc	o use contribute to	the cause of death?
rds	quires n sign	d by					1 🗆 Yes	2 No 3 Pr	obably 4 Duknown
Records,	s been si	Completed				24a.	. Was an	24b. Were au	topsy findings available
	The law	mo				1 🗆	autopsy performed? Yes 2	? death?	completion of cause of
Vital		Bec	25. Was case referred to medical examiner?		26. P	Place of Death (Check			
	Physic this ce al dire	To	1 Yes 2 Hospital: 1	Inpatient 2 ER/Outpati		ursing Home 5			city)
D C	ling P	:HO	1 Deatural 5 Pending (Mo	e of Injury 28b. Time onth, Day Year) Injury	Work?		cribe how in	jury occurred	
Sic	ottendii de th. ctor: A y the fu	icht	2 Accident investigation 3 Suicide 6 Could not be	ce of Injury - At home, farm,	M 1 Yes 2		tion (Street	and Number or Pi	ıral Route Number,
Division of	after Direct	Certification:	4 Homicide determined 289. Flat buil	ding, etc. (Specity)	street, factory, office		or Town, Sta		nas noute vulliber,
	To the Hospitel or Attending Physicien: whith 24 hours after deals. To the Funerel Director: After this certifica completely filled in by the funeral director,		29a. Certifier 1D Certifying Physician: To the	ne best of my knowledge, de	ath occurred at the time, date	e and place, and due	to the cause	(s) and manner as	stated.
	n 24 h	edical	(Check only 2 Medicel Examiner: On the	basis of examination and/or inner stated.	investigation, in my opinion,	death occurred at the	time, date a	and place, and due	to the cause(s)
	To 1 To t	Σ	29b. Signature and title of certifier	-	29c. License numb	ber . O.C	29d. [	Date signed (Monti	h. Day, Year)
			Swindy (C)	Wille M	1 027	188		116/6	
	6		30. Name and address of person who completed ca	use of death (Item 23a) (Type	e, Print)	Place D	11	1201 A.	10 2/222
	Sta	te	31. Date filed (Month, Day, Year) 2007 32,	Registrar's Signature	backs	are 1	una	WIL 10	y HELL
•	Registr		JUL 0 9 ZUUT	Shire to be					

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 3:09 AM SINGLETON HILDA Jul /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Center Medica BALTIMORE Dayview If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□M 25 F 218-26-5389 FEBRUARY 17,1931 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show 1 Yes 2 No BALTIMORE Directo MARYLAND 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number or iteme 23s or S. H STREET CROSS 130 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 □ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: BLACK þ 3 ₩Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) other than Elementary/Secondary (0-12) College (1-4or 5+) AUTHORIZER SOCIAL SECURITY ADMIN. permit. Pages 1 and 2 should be file.
Department of Health and Mental Hyg important: if Item 27 is marked other eny injury or other traumett 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ( BROWN JAMES 100 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 130 W. CROSS ST, BALTIMORE, MD 2123C CINDA DAVIS (NIECE) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State MT. ZION CEMETERY 07-10-07 LANSDOWNE, MARYLAND □Denation 5 □ Other (Specify) 22. Name and Address of Facility 2140 N. Fulton Avenue Baltimore Signalure of Funeral Myice License YJOSEPH Filer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, of heart failure. List only one cause on each line. remediate cause (Final 4 sease or condition esulting in death) Myocardial Physician /Medical Due to (or as a consequence of) Examiner COTONON Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequent of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Completed by Physician/Medical for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 No Day 4☐Pregnant at time of death 5 Other (specify) o 9☐ Unknown 9 Unknown م Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 1 Yes Division of Vital the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Natural 5 Pending investigation s after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature 29c. License number 61 07 D0062194 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore योर्ध 301 Chintan Desay 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2007 Registrar

Hilola Singleton

# permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Baltimore, Maryland 21215-0036

Phy /Mo Exa

Division or Vital Records, P.O. Box 68760,~

		For State Amer Registrar	nd #17,18	State of perFH, G86	Maryland 9, 7/9/0	d / Depa 7 TT <sub>Cel</sub>	artmen rtificat	t of H e of L	ealth an Death	nd Mer		giene Reg. No.	2017	21925
hysicia		1. Decedent's Name				2.	2. Date of Death Month Day 7/1/2007		Year	3. Time of Death  3:30pm				
/Medic Examin		4a. Facility Name (// Gilchres		4b. City, Town, or Location of Death  Towson MD						County of Death  N/A				
ineral rector		5. Social Security Number 446–48–7413		6. Sex 7. Age		(In yrs. last birthday) 68 Yrs.		If Under 1 Year if Under 24 Hrs.  Months Days Hours Min.		Hrs. 8. Min.	8. Date of Birth (Month, Day, Year) 08/06/1938		9 Birth	place (State or Foreign ntry) Germany
show	or	Usual Residence of 10a. State MD	ward	10c. City		eation Licott City						10d. Inside City Limits 1 ☐ Yes 2☐ No		
3a or 28a-1 st be notifi	Be Completed by Funeral Director	10e. Street and Number 9619 Sparrows Court				10f. Zip Code <b>2104</b> 2						10g. Citiz	en of What Cou	
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		11. Marital Status  1 □ Never Married 2 ★ Married  1 □ Never Married 2 ★ Married  1 □ Yes 2 If Yes, Give  Year or Dat			ces? 2∕∏ No e	If Yes, specify Cuban, Mexica			spanic Origir n, Mexican, I Specify:				14. Race - American Indian, Black, White, etc.  Specify: white	
an "natural Medical Ex		15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5				(Give kind of work done during most of working life. DO NOT use retired)						d of Business/Ir		
ed other the		12 17. Father's Name Philip Philip	(First, Middle,	Last)			НО	usew.	18. Mother's	gart	First, Middle, Nauma	Maiden S	sidenti: Surname)	al
27 is mark r traumatí	To	19a. Informant's N Dan Set						,		or Rural F			Town, State, Zi	
ant: if item ary or othe		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Millbank Cemetery  July 6,2007  Fredonia, PA												
Importa any inju once.		21. Signature of Funeral Service Licensee Victor P. Doda  Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Avenue, Baltimore Maryland 21230												
sician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition  CO CACCR  Approximate Interval Between Onset and Death  List only one cause on each line.  Approximate Interval Between Onset and Death  List only one cause or cardiac or respiratory arrest, and Death  List only one cause on each line.												
edical miner	Examiner	Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):												
physician and s the burial-transit		cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):									<u></u>			
g physicia as the bu	edical			d										
To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was deceder in the past 12 1 ☐ Yes 2 9 ☐ Unknown	months?		3 ☐ Ectopic pregnancy 5 ☐ Other (specify)				23d. Date of delivery  Month Day		,			
n signed build be deta	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to 1 Yes 2 No 3 P												
ate has bee page 2 sho	Completed												24b. Were aut prior to c death? 1 \( \text{Yes}	topsy findings available ompletion of cause of
s certific director,	o Be	25. Was case refe examiner?	/	Hospital:	npatient 2	ER/Outpatie	nt 3 □ D6	OA Oth	ar.		Check only o		Sother (Spec	HOSDICE
r: After thi	ation: T	27. Manner of Dea 1 Natural 2 Accident	th 5 Pendir investi	of Injury th, Day Year)	□ ER/Outpatient 3 □ DOA						104			
ai Directo ed in by th	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could determ	of injury - At ho ng, etc. <i>(Specif</i>	y - At home, farm, street, factory, office 28f. Local (Specify) 28f. Local City (						ocation (Street and Number or Rural Route Number, try or Town, State)			
the Funer pletely fills	Medical (	29a. Certifier (Check only one)	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)											
0 L	Z	29b. Signature and title officertifier  29c. License number  29d. Date signed (Month, Day, Year)  30(72, 2007)												
)		30. Name and add	ressof person	who completed caus	e of death (Item	23a) (Type	Print) V-Cl	houl	es St.	Ba	Cto.	md	7120	7
Sta Registi		111 0 0 /     /   /   /   /   /   /   /   /												

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Ma		partment of e <i>rtificate o</i> a	Health and N f <i>Death</i>		iene eg. No.?	7 91027				
	Physici	an	1. Decedent's Name (First, Middle, La	st) earman Sr.				2. Date of Deat	Day Yes	3. Time of Death 8:55p M				
X	/Medic Examin		45 City Town or Location of Dooth							eath				
15	Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month Pay, Year) 1928							Yeard 9.	Birthplace (State or Foreign Country)				
	land ow at		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits				
036	e Mary Ba-f sh	ctor	Ks Doug	1as			Lawrence			1X Yes 2 □ No				
	h with th 23a or 28 st be no	Funeral Director	10e. Street and Number 3000 Yellowstone Drive 10f. Zip Code 10g. Citizen of What Cou											
	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examiner must be notified at	þ	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent En Armed Forces? 15€ Yes 2 □ No If Yes, Give Year or Dates:	ver in U.S. 1		Vas Decedent of Hispanic Origin? (Specify Yes or No- Yes, specify Cuban, Mexican, Puerto Rican, etc.)  Yes 2X No Specify:			merican Indian, /hite, etc. 31ack				
21215-0036		Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+	(Gi	16a. Decedent's Usual Occupation (Give kind of work done during most of worki life. DO NOT use retired)  Industrial Engineer			16b. Kind of Busine Manufac					
Q	should be filed within and Mental Hygiene. s marked other than *	To Be Co	17. Father's Name (First, Middle, Lass John Leland Spe				18. Mother's Nam Rose	ne (First, Middle, 1 Hutcher	Maiden Surname) SON	Surname)				
Mary	nd 2 shoulth and M 27 Is mai	-	19a. Informant's Name/Relationship John Spearman Jr	Type. Print) Son	19b. Ma 122	iling Address (Stree Foxtrap	Drive, Gl	ral Route Number en Burni	e, MD 210	0. Zip Code) 061				
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked, any injury or other traumatic ev once.		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Speci			position (Name of rematory or other p Cemete)	July		20c. Location - City Lawrence					
Balt	permit. Departi Importi any inj		21. Signature of Funeral Service Lice	- Mar Acal	u	22. Name and Add Charles 1501 Eas	ress of Facility L. Steven St Fort Av	s Funera Venue, Ba	l Home II	nc. MD 21230				
*			23a. Part1. Enter the disease, or con shock, or heart failure. List only	one cause on each line	€.		ying, such as cardiac	or respiratory arr	est,	Approximate Interval Between Onset and Death				
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  Renal Failure  Due to (or as a consequence of):											
	Examiner		Sequentially list conditions.	Coronary Artery Disease										
1	nsit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a										
. '09289	icate be executed physician and s the burial-transit	dical Exa	resulting in death) Last	d										
x 68	ertifica ling ph e as th	Medi	IF FEMALE:	00. 11										
.O. Box	at the death certifi by the attending tached for use as	ysician/	Physician/Me	ysician/	ysician/	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown  23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown							of delivery th Day Year	
Δ.	ss this	þ	Part II. Other significant conditions Hypertensive C				given in Part I.			e to the cause of death?  Probably 4 1 Unknown				
or Vital Records,	law require as been si 2 should b	Completed	Diabetes				24a. Was an 24b. Were a		autopsy findings available					
E B	The ate h	Com	Atrial Fibrill	ation		perform	autopsy prior to completion death?  1 Yes 2 No 1 Yes 2 No							
Vita	Physician: The this certificate ral director, pag	Be c	25. Was case referred to medical examiner? 1 ☐ Yes ★★No	Hospital:	t 2 🕱 ER/Outpat	ient 3 DOA	ther:	ath (Check only on						
1 OF		n: To	27. Manner of Death	1 Inpatien 28a. Date of Injury (Month, Day	/ 28b. Time	of 28c. In	4 🗆 Nursing n		ence 6 Other (5 ow injury occurred	specify)				
Division	teath leath tor: the	Certification:	2 Accident investigatio 3 Suicide 6 Could not b	n Place of injur		M 1	☐ Yes 2☐ No	28f Location (St	treet and Number o	r Rural Route Number				
Σ	spital or Attend tours after death neral Director: / / filled in by the f	Certif	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rura City or Town, State)											
	To the Hospital or Al within 24 hours after of To the Funeral Direc completely filled in by	Medical		hysician: To the best of miner: On the basis of and manner stat	examination and/or									
	To the within to the complex c	M	29b. Signature and title of certifier  29c. License number MD 12134  29d. Date signed (Mont July 6, 2)							onth Day Year) 2007				
	12		30. Name and address of person who Patricia Davids	completed cause of decon, M.D.	ath (Item 23a) (Tyr 106   Irvir	e, Print) Ig St. Was	shington I	oc, 20010	)					
	Sta Registi		31. Date filed (Month, Day, Year)	32. Registral	r's Signature	Cartie								

DHMH 17 Rev 1/2001

AMEND TTFM/9 perFH 2869 7/9/07 W State of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 1:07 P M SOO /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE AGNES HOSPITAL TUIAS If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Hours | Min. | Min. | Month, Day, Year Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** Days 349-22-616 Usual Residence Months 1 M 2 F Director SC permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If then 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Nes 2 No Funeral Director 5a.Himore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ 3 ☐ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 18. Mother's Name (First, Middle, Maider, Be ၉ 19a. Informant's Name/Relationship 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 □ Cremation Rochville, Md 3 ☐Removal from State İD 4 □ Donatie 5 Other (Specify) 21. Signatu saltimac, Md 21229 Baltimare disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ailure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician ONGESTIVE FAILURE HEART 2YAQ /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, in a ling to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal dea 4□Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy 2 Fetal death in the past 12 months? Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Inknown Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 No 24a. Was an autope performed or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death

1 Natural

2 □ Accident 28a. Date of Injury 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation (Month, Day Year) Injury М 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) ģ 4 Homicide the Hospital 🔁 certifyIng Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier P20656 JULY 5, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 900 CATON AVE. BALTIMORE MD 21229 KONSTANTIN ZUBELEVITSKIX 32. Begistrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3 Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 20:10:M stankiewicz 29 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Bayview Medical Center 7. Age (In yrs. last birth Johns Hookins 8. Date of Birth (Month, Day, Year) If Under 1 Year Birthplace (State or Foreign Country) Social Security Number **Funeral** Days Months Hours 1**X** M 2□ F 75 218-26-3745 Maryland Director June 1,1932 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a State 10h County r 28a-f sh notified a 1 ☐ Yes 2 No Director Dundalk Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ns 23a or 2 must be n United States 21222 2006 Denbury Drive Funeral items ? 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 ☐ Yes 2 If Yes, Give 1 Never Married 2 Married 20 No 6 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Specify: 2 3 Widowed 4 Divorced White "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry is marked other than "natu aumatic event, the Medical Baltimore City Elementary/Secondary (0-12) College (1-4or 5+) Fire Department Firemen 8 Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and 2 should be and Mental Frances V. Myslinski Joseph P. Stankiewicz 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2006 Denbury Drive Dundalk, Maryland 21222 Frances Rose Stankiewicz (Wife) Department of Health Important: If item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition 6 1 ⊠Burial 2 ☐ Cremation 3 ☐Removal from State Sacred Ht. of Jesus Cem. 7/3/2007 Dundalk, Maryland injury 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 21. Signatur Funeral Service Licensee 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cau e (Final disease or condition resulting in death) Due to (or as a contequence of): Physician /Medical Examiner Abdominal Acrtic Angurym if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine tran and Due to (or as a consequence of): physician a pe Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No has autopsy nerformed certificate I 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 ✓ Yes 2 ☐ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 patient P this 27. Manner of Death
1 Natural 28a. Date of Injury (Month, Day 28b. Time of Injury at Work? 28d. Describe how injury occurred After t al or Attending P after death. Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 8 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide To the Hospital of within 24 hours of To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

12

21215-0036

Baltimore, Maryland

Box 68760,

P.0.

Vital Records,

o

Division

State Registrar 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

P. 4940 E 39 Registrar's Signature

FASTERN AVENUE BALTIMORE

D0036233

State of Maryland / Department of Health and Mental Hygien

			1 - State Registrar		tificate of Death		Reg. No.	7 9 1 0 9 h			
8	Physici /Medio		1. Decedent's Name (First, Middle, Last)  Nelson E. Smith			2. Date of De Month July 4,		3Time of Death			
	Examin		4a. Facility Name (If not institution, give street and number) 6205 Marietta Avenue		4b. City, Town, or Location of	of Death	4c. County of De				
Ę.	Funeral Director		5. Social Security Number 6. Sex 1 $\times$ 1 $\times$ M 2 $\square$ F 8.	yrs. last birthday) 4 Yrs.	Baltimore If Under 1 Year If Under 2 Months Days Hours	24 Hrs. 8. Date of Bir (Month, De 11/9/19/2	ay, Year)	Birthplace (State or Foreign Country) Bryland			
36	/land ow		Usual Residence of Decedent  10a. State 10b. County 10c	c. City, Town or Loc	cation			10d. Inside City Limits			
	e Mary Ba-f sh ptified	ctor		Baltimore				1 💢 Yes 2 🗆 No			
	ath with th 23a or 20 wst be no	Funeral Director	10e. Street and Number 6205 Marietta Avenue		10f. Zip Code 21214		10g. Citizen of What USA	Country?			
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Fune	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced  12. Was Decedent Ever Armed Forces?  1 ☑ Yes 2 □ No If Yes, Give Year or Dates: WW.	l II	Vas Decedent of Hispanic Orig Yes, specify Cuban, Mexican ☐ Yes 2 <b>X</b> No Specify:	gin? (Specify Yes or No n, Puerto Rican, etc.)	Specific	merican Indian, hite, etc. <b>Whit</b> e			
2-00	72 hou 'natura dical E	eted	15. Decedent's Education (Specify only highest grade completed)	16a Deced	ent's Usual Occupation kind of work done during most OO NOT use retired)	t of working	16b. Kind of Busines				
21215-0036	within iene.	Completed by	Elementary/Secondary (0-12) College (1-4or 5+)	ı	ce Technician	, or worming	B.G.E				
	be filed ttal Hyg d othel event,	To Be C	17. Father's Name (First, Middle, Last)  Edwin H. Smith			r's Name (First, Middle					
Maryland	should nd Mer marke imaric		19a. Informant's Name/Relationship (Type. Print)	19b. Mailin	Lillia g Address (Street and Numbe		er, City or Town, State	e. Zin Cade)			
	and 2 ealth a m 27 is		Leslie Kravitz / Daughter	350 Key	West Drive Char	lottesville,	VA 22911	, 2.0 0000)			
nore	ages 1 ent of H nt: if ite y or otl		I   Dullai 2   Cremation 3   Nettional Itolia State		sition (Name of natory or other place) morial Park 7	Date 7/7/2007	20c. Location - City	,			
Baltimore,	permit. F Departme Importan any injur		21. Signature of Funeral Service-Licensee	22	Name and Address of Facility Onard J. Ruck, Ir	y 5305 Har	Baltimore, rford Road re, Maryland				
	1000		23a. Part1. Enter the disease, or complications that cause the shock, or heart failure. List only one cause on each line.					Approximate Interval Between			
	Physician		Immediate Cause (Final disease or condition resulting in death)  a. BILATERAL PNEVMONIA  DAYS								
	/Medical Examiner		Due to (or as a con								
<i>h</i> .	ed sit	Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	risequence of):							
o O	execut an and rial-trar		that initiated events resulting in death) Last c. Due to (or as a cor	nsequence of):		<u> </u>					
68760,	rtificate be executed og physician and as the burial-transit	edical	d								
.O. Box 6	The law requires that the death certifite has been signed by the attending lage 2 should be detached for use as	by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome pf pr 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of o	delivery Day Year			
Records, P.	uires that i signed by id be deta		Part II. Other significant conditions contributing to death but not  MALICINANT PLENT			23e. Did t		to the cause of death?  Probably 4 dunknown			
eco	ne law requir has been si je 2 should t	Completed					24a. Was an 24b. Were autopsy finding				
			OF Was and Associated			1□ Yes	ormed? death	o completion of cause of ? es 2 No			
r Vital	hysiclan: nis certifica I director, I	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient	2 ER/Outpatient	Other	of Death (Check only of Death (Check only of Presing Home 5. ☐ Resi		pecify)			
n or	ding Pl		27. Manner of Death 1 Natural 5 Pending (Month, Day Yea	28b. Time of Injury	28c. Injury at Work?	28d. Describe	e how injury occurred				
Division or	To the Hospital or Attent within 24 hours after death To the Funeral Director; completely filled in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 6 Homicide 6 Homicide 6 Homicide 1 See. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)								
	To the Hospital or Al within 24 hours after of To the Funeral Direc completely filled in by	Medical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my one and manner stated.	/ knowledge, death mination and/or inv	occurred at the time, date and estigation, in my opinion, deat	d place, and due to the th occurred at the time,	cause(s) and manner date and place, and c	as stated. lue to the cause(s)			
	To the within To the comple	Me	29b. Signature and title of certifier		29c. License number		29d. Date signed (Mo	onth, Day, Year)			
		-	30. Name and address or person who completed dayse of death	(ltom 92a) (T 5	U348	21	7/6/5	7			
	12		JAMES EBEING M	(Item 23a) (Type, F	OSUER DI	RIVE SVITE	101 TOWS	N MD 21204			
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's S	Signature H. A	C. W.			7			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07-05063 State of Maryland / Department of Health and Mental Hygiene Orrin E Thomas 1- For State Certificate of Death Reg. No. Registrar 2. Date of Oeath 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day July 2, 2007 Year 1816 hrs Medical Examiner 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death 2411 St. Stevens Court Apartment 2A **Baltimore** If Under 1 Year | If Under 24Hrs. 9. Birthplace (State or 6. Sex 7. Age (In yrs. last birthday) Date of Birth (MM/DD/YYYY) 5. Social Security Number **Funeral** Months Days Hours Min. Director Country) XМ 2 F Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 No ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natural", or items 23a or 28a-f shov or other traumatic event, the <u>Medical Examiner must be notified at once.</u> Director 10g. Citizen of What Country 10e. Street and Number -11 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-Funeral 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2 Never Married Married Yes Yes 2 X No specify: 4 X Divorced Yes. Give Year Specify: ð 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Flementary/Secondary (0-12) Pages 1 and 2 should be filed within 721 MD 21215-0036 7 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print.) Date 20b. Place of Disposition (Name of cemetery, 20a Method of Disposition Baltimore, 3 Burial 2 Cremation Other Specify: Donation 5 22. Name and Address of Facility 21. Signature of Funeral Service Licens oseph First. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart filter. List why one cause on each line. Approximate Interval Physician Between Onset and /Medical Death Chronic alcohol abuse Immediate Cause (Final disease **⊘** Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Physician/Medical X UNPENDED #23a,27,perME,G869, attending physician or use as the burial P.O. Box 68760 23d Date of delivery 3b. Was decedent pregnant in the 3 Ectopic pregnancy Year Month Day Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Linknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. ð Yes 2 No 3 Probably 4 ✔ Unknown Division of Vital Records, Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? certificate has performed? Yes 2 No ✓ Yes 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 Nursing Home 5 Residence 6 ✔ Other: Scene Inpatient 2 ER/Outpatient 3 this 1 V Yes 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) After 27. Manner of Death 28b. Time of Injury Certification: 1 X Natural Yes 2 No e Funeral Director: A Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifi July 3, 2007 O.C.M.E. 30. Name and address of perso who completed cause of death (Item 23a) Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201 Jack Titus MD.

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year,

			For State Registrar	State o	of Marylan		artment of F ctificate of		_	giene Reg. No.	01	1.100	
		6.8	1. Decedent's Name (First, Middi				Date of Death     Month Day Year		3. Time of Death				
ы	Physici /Medic		Adele Hattie			7	7 5 200		12:20 A.M				
	Examin		4a. Facility Name (If not institutio	n, give street and nu	ımber)		4b. City, Town, o	r Location of Deal	th	4c. County	y of Death	1	
		6.	Gilchrist Ce	enter			Towson			Bal		ore	
1	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	-	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		th ay, Year)	9. Birth	place (State or Foreign intry)	
	Director		273-07-0587	1 □ M 2 💢 F	9	5 Yrs.			3/22/			reland, Ohio	
	pu ,		Usual Residence of Decedent 10a. State 10b. County	,	10c Cit	y, Town or Lo	cation					10d. Inside City Limits	
	aryla shov d at	Ž			100.011							1 □Yes 2√No	
	Ba-f Sa-f	Director		ltimore		Phoe:				10 000	115 0		
	vith ti	Dir	10e. Street and Number				10f. Zip Code			10g. Citizen of	wnat Cou	intry r	
	ath v	ra	3723 Dance Mil			0 10	2113		2	USZ		Soon Indian	
	er de	Funeral	11. Marital Status	Armed F		.S. 13.	Was Decedent of H If Yes, specity Cub	an, Mexican, Pue	specity Yes or No ito Rican, etc.)		ick, White,	ican Indian, , etc.	
36	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examiner must be notified at	by F	1 ☐ Never Married 2 ☐ Mar 3 ※ Widowed 4 ☐ Divorced	fried I Tes If Yes, G Year or D	2010 ive		1 □ Yes 🎎 No	Specify:		Specif	fy: N	Thite	
8	hour tural	be t		nt's Education	Jaico.	16a, Dece	dent's Usual Occup	pation		16b. Kind of B			
5	n 72 i "na ledic	Completed	(Specify only highe	est grade completed)		(Give	kind of work done DO NOT use retire	during most of wo	orking			,	
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9	filed Hygi other		17. Father's Name (First, Middle	, Last)				18. Mother's Na	me (First, Middle				
Maryland 21215-0036	d be ental ced c	To Be	Richard Hern	nan Berndt	-			Emi]	ly Spich	alski			
$\overline{\leq}$	shoul nd M mari	F	19a. Informant's Name/Relations	ship (Type. Print)		19b. Mailir	ng Address (Street	and Number or F	aral Route Numb	oute Number, City or Town, State, Zip Code)			
	od 2 ulth a 27 is rtrau		Reatha Burk-d	laughter		372	3 Dance N	Mill Road	d Phoeni	x, Mary	land	21131	
ā,	s 1 and 2 of Health a Item 27 is		20a. Method of Disposition		20b. I	Place of Dispo	sition (Name of	ce) T1-	Date	20c. Location	- City or T	own, State	
30	Page ent o nt: If		M∑Burial 2 □Cremation 4 □Donation 5 □ Other (		State St	John'	matory or other pla s Luther a	$\frac{1}{200}$	79 <b>,</b>	Phoeni	ix, M	Maryland	
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	li	21. Signature Juneral Service		/		Cemetery  2. Name and Addre	1					
B	permi Depar Impor any ir		My do k	Sill							nd 21	on Ctr.,P.A.	
			23a. Pa <b>f</b> t1. Enter the disease, o shock, or heart failure. Lis	r complications that t only one cause on	caused the deat each line.	th. Do not ent	er the mode of dyi	ng, such as cardia	ac or respiratory a	arrest,		Approximate Interval Between Onset and Death	
	Physician		Immediate Cause (Final disease or condition	_a Ì	Schem	IC C	ording	orathy				4 cors	
	/Medical Examiner		resulting in death)	Due to	(or as a consec	uence of):		'				,	
8	Examine		Sequentially list conditions,	b	,	41							
	ed sit	ine	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events	Due to	Due to (or as a consequence of):								
,	and tran	Examiner	that initiated events resulting in death) Last	C	(or as a consec	mence of).							
8760,	ficate be executed physician and s the burial-transit				(4. 44. 44.	,,							
87	cate physi the I	dical		d									
9 X	± 0 €	Physician/Me	IF FEMALE:	23c. If yes, or	utcome pf pregn	ancv				234 D	ate of deliv	Non	
Вох	eath catternation	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live	birth 2 Feta	al death 3	Ectopic pregnanc Other (specify)	у			lonth	Day Year	
	the de	ysic	1 ☐ Yes 2 ♠ No 9 ☐ Unknown	9□Unki		JOHN OL	_ Other (apouny) _						
P.0	that the death cer led by the attendir detached for use		Part II. Other significant condit	ions contributing to	death but not res	ulting in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco use cor	ntribute to	the cause of death?	
Records,	w requires t been signe should be o	d by							1 🗆	Yes 2 No	3 ☐ Pro	obably 4 Unknown	
Ö		Completed							24a. Was	24h	Were au	topsy findings available	
Rec	e la has je 2	ם							auto	opsy ormed?	prior to or death?	completion of cause of	
a			07 U	,					1□ Yes	2 <b>X</b> No	1 🗆 Yes	2 No	
Vital		Be	25. Was case referred to medical examiner?	Hospital:	Negation OF	ER/Outpatier	ott	or:	eath (Check only			1. 1 Les . 140	
ō	Phys r this ral di	<u>유</u>	1 ☐ Yes 2 Ŋ No  27. Manner of Death	28a. Date		28b. Time o	IL 3 DOA	4 □ Nursing	Home 5 ☐ Res	how injury occu	ther <i>(Spec</i> irred	city) TOSP14	
on	ding h. Afte fune	ion	1 Natural 5 ☐ Pendi	/8.0-	nth, Day Year)	Injury		rk? ]Yes 2 ∐ No		,,			
Division	Attending r death. ector: After	fica	3 ☐ Suicide 6 ☐ Could	I not be 28e. Plac	e of injury - At h	l ome, farm, sti	reet, factory, office		28f. Location	(Street and Num	ber or Ru	ral Route Number,	
á	affer affer bire	Certification:	4 ☐ Homicide determ	build	ding, etc. (Speci	fy)			City or To	own, State)			
	To the Hospitallor Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		(Check only 2 Medica	ing Physician: To the	basis of examina								
	To the within 2.	Medical	one) 29b. Signature and title of certifi		nner stated.		29c. Licens	se number		29d. Date sign	ed (Month	ı, Day, Year)	
	->-0		> alre	luy			1) 5	8303		July S	20	07	
	13		30. Name and address of person	n who completed car	use of death (Iter	m 23a) (Type,	Print)			1			
			AARON J. C	HARVES	W) (	6701	N. Ch	artes !	St 700	rson r	10 6	21204	
	Sta Regist		31. Date filed (Month, Day, Year	2007	Registrar's Sign	Span	E.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1tem 25 per doc 9869 7-9-07 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month 2607 Helen CK /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BAltimore herry ATC eisterstown If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month, Day, 6. Sex Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (i yrs. last birthday) **Funeral** Year) 1 □ M 2 F 212-34-9178 Yrs. MARYLAND Director Dec Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1/2 Yes 2 □ No Funeral Director MARYLAND Altimore 10e. Street and Number 10g. Citizen of What Country? . Was Decedent Ever in U.S. Armed Forces? 21224 145 Pages 1 and 2 should be filed within 72 hours after deathment of Health and Mental Hygiene. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: 3 ☐ Widowed 4 ☑ Divorced White "natural", Completed If item 27 is marked other than "nature or other traumatic event, the Medical or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) cheer leader 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be KENUONGA NMONY ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 12 W GRACE M. BENUCNEA 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 □ Cremation 3 □ Removal from State Department of Important: If any injury or once. July 10, 2007 BAHIMORE, MARYLAND 4 Donation 5 Dother (Specify) 21. Sign re f Funeral Service Licensee Name and Address of Facility
SEPL N. ZANNINO Jr.
1635-CONKLING ST BAILE wwino Jr. Fus MD 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure, List only one cause on each line. Approximate Interval Between Immediate Cause (Findisease or condition resulting in death) Onset and Death cordiumyorami **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, and the last cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off: Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending phi for use as the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 5 ☐ Other (specify) ed by the a 9☐ Unknown 9 Unknow ate has i een signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by renal injufficiency, amulfimilianon, 1 ☐ Yes 2 No 3 Probably 4 □Unknown 11/Or disease, mainumnon, bipular disavaer,

nyrumyrudicm, COPD, Ceremoruscular disease

25. Was case referred to medical
examiner?

Haenital.

Haenital. 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes funeral director. 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Certification: To this 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t 1 Natural 5 ☐ Pending investigation Injury after death.

I Director: Aff
in by the fur 1 🗌 Yes 2 □ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 060680 of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address 750 Main St. Keisterstown, MO 21136 MILITEU 31. Date filed (Month, Day, State JUL 0 9 2007 Registrar

				Type or Prin AMEND ITEM State of Ma	t in Black	k Indelib	le Ink. ht 6f Fr	Ensur O7, WS	e All (	Copies	Are giene	Legible		
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	vith the M a or 28a-f be notifie	Director	10e. Street and Number	. 1/2 61		14/106. Z	Zip Code	11			10g. Citi	zen of What	Country?	
	eath v ns 23a must	eral	1410 Brix WOI	12. Was Decedent E	APT. / C	13. Was Dec	cedent of Hi	Spanic Origin	n? (Snecif	v Yes or No	)- T	14. Race - An	nerican Indian,	
36	filed within 72 hours after death with the Maryland Hygiene. Hygiene, they than "natural" or items 23a or 28a-f show ant, the Medical Examiner must be notified at	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1  Yes 2  N If Yes, Give Year or Dates:		13. Was Dec If Yes, sp 1 ☐ Yes	2 No	Specify:	Puerto Rio	can, etc.)		Black, WI		
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Ē	es 1 au of Hea of Item		20a. Method of Disposition		20b. Place of	Disposition (N	lame of r other place	e)	Dat	8	20c. Lo	ocation - City	or Town State	C
altimore.	Pages ment of ant; If Its ury or o		1 Desurial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Speci	fy)	Coar	rson	Horas	+ 7	7/10,	107	Ow	MISM	ill, Md	
Balt	permit. Pag Department Important; I any Injury o		21. Signature of Funeral Service Lice	Mee Man	4.0	Valley	and eddres	3/1997	1e F	wer	215	its.		
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	/Medical		disease or condition resulting in death)	a.	consequence	of):	20	IVC	1	FN C	<del></del>	-	7 46	ANS
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	To the To the Complete	Me	29b. Signature and little of certifier				29c. License				29d. Da	te signed (Mo	onth, Day, Year	)
			1720	2 00				617			500		1 20	07
	1		30. Name and address of person who	completed cause of de	ath (Item 23a) (	(Type, Print)	V 127 C	ANIE	十?-	2 Ro	( 110	noin F	mp 2	1275
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DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Maryland		tificate of Dea			giene Reg. No.	
B	Physici	an	1. Decedent's Name (First, Middle, Last,	)				2. Date of Dea Month		3. Time of Death
	/Medi		Kenneth	Webster		Wingate		July 4,	2007	12:45 p M
	Examir	ner	4a. Facility Name (If not institution, give			4b. City, Town, or Loca			4c. County of [	
-			12329 Bonmot F  5. Social Security Number 6. Second		et hirthday)	Reister	Inder 24 Hrs.	8. Date of Birt	Balti	
	Funeral Director			M 2□F 77	Yrs.		ours Min.	(Month, Day	0, Year) 0, 1930	Birthplace (State or Foreign Country) Maryland
	land ow at		10a, State 10b. County	10c. City,	Town or Lo	cation				10d. Inside City Limits
	Many Ffsh fied	ţ	MD Baltim	nore		Reisters	town			1 □ Yes 2 No
	h the	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wha	t Country?
	th wit		12329 Bonmot	Place		211	36		U.S.	Α.
	r dea ems	Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	. 13. V	Was Decedent of Hispan f Yes, specify Cuban, Me	nic Origin? (Spe exican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - A	American Indian, Vhite, etc.
36	s afte	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1  Yes 2 No If Yes, Give			ecify:	, ,	Specify:	White
9	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ont, the Medical Examiner must be notified at	ed b	15. Decedent's Edu	Year or Dates: 50	54 Decec	lent's Usual Occupation			16b. Kind of Busine	
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р	be filed Ital Hygi od other event, t	Be	17. Father's Name (First, Middle, Last)			18. 1	Mother's Name	e (First, Middle,	Maiden Surname)	
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylar f Heaith and Mental Hygiene. If marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	L <sub>O</sub>	Kenneth	W. Wingate,	Sr.		He1e	n	Unknow	n
Jar	12 sh nand rsum		19a. Informant's Name/Relationship (Ty	(1)		g Address (Street and N				te, Zip Code)
	s 1 and 2 of Health item 27 I		Nancy Derr 20a. Method of Disposition	Daughter		reenlow Roa		onsville Date	e, MD 21  20c. Location - City	228
jo			1 ☐ Burial 2 【Cremation 3 ☐ F	lemoval nom State		sition (Name of natory or other place)			,	,
Baltimore,	サードでき	9	4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service License			remation Se . Name and Address of I				d, Maryland
Ba	permi Depar Impor any ir		Stephen	M. Jenke	ns El	ine Funeral	Home 1	Reister		
Š			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the death. ne cause on each line.	Do not ente	er the mode of dying, suc	ch as cardiac c	or respiratory ar	rest,	Approximate Interval Between Onset and Death
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4	/Medical Examiner		Toodking in dodkin	Due to (or as a conseque	ence of):					
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Вох	eath cert attending for use	ian/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome pf pregnan 1 ☐ Live birth 2 ☐ Fetal of	death 3□	Ectopic pregnancy			23d. Date of Month	delivery Day Year
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ita		BeC	25. Was case referred to medical			26. I	Place of Death	1 Yes ∩ (Check only or		Yes 2 No
<u>-</u>	ys dir	To	examiner? 1 Yes 2 No	lospital: 1 ☐ Inpatient 2 ☐ E	R/Outpatient	Othor			ence 6 Other (S	Specify)
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sio	Attending r death. ector: After by the funer	cati	2 Accident investigation 3 Suicide 6 Could not be	00 51 411		M 1 ☐ Yes				·
Division or Vital Records,	I or Attendate death Director:	Certification:	4 Homicide determined	28e. Place of injury - At hom building, etc. (Specify)	ie, farm, stre	et, factory, office	2	28f. Location (S City or Tow		r Rural Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		(Check only 2 Medical Examin	sician: To the best of my knowled ner: On the basis of examination	edge, death	occurred at the time, da	ate and place, a	and due to the o	cause(s) and manne	r as stated.
	To the within 2 To the Complet	Medical	one)  29b. Signature and title of certifier	and manner stated.		29c. License num			29d. Date signed (M	
<b>\</b>	Ĕ¥Ĕ8	-	<b>)</b> \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	1 ()		DZN			T	onus, vay, rear)
10 2			30. Name and address of person who co	mpleted cause of death (Item 6	3a) (Type 5				1/2 (3)	
53	4		Judah	No No Company Signature	1	pole	- S'	< 5	e. stento	own nd
	Sta Registr		31. Date filed (Month, Day, Year)	32. Redistrar's Signatu	K A	poele				

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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 12:35 PM QUEENIE S. WEBB 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** UNION MEMORIAL HOSPITAL N/A BALTIMORE 6. Sex If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Months Days Hours 1 □ M 2 🕱 F Director 88 VIRGINIA 217-16-0316 11-22-1918 Usual Residence of Decedent the Maryland 10a State 10c. City, Town or Location 10h County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at annes. 1. Yes 2 No Director MD. N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1020 33rd ST. APT 301 21218 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No þ 3 X Widowed 4 □ Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) -8--0-NURSING ASSISTANT HEALTHCARE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JOHN EWELL ANNIE GREEN ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RUDOLPH COOK (NEPHEW) 4702 SALTERFORTH PLACE ELLICOTT CITY, MD. 21043 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1K Burial 2 ☐ remation ☐Removal from State ARBUTUS MEMORIAL PARK 7-11-2007 BALTIMORE, MARYLAND 4 ☐ Donation Other (Specify) D: HIBNER Name and Address of Facility REDD FUNERAL SERVICE 21. Signature of F neral ervice Licensee JONATHAN 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or feart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** disease or condition resulting in death) 4 Hours /Medical Due to (or as a consequence of) Examiner pertension Unknown Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) physician Physician/Medical attending p IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ☐Unknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No page 2 autopsy performe certificate 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ☑ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No ၉ 1 Inpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Affer 1 Natural 5 Pending investigation Injury 1 Tes 2 □ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical

Division or Vital Records, P.O. Box 68760, within 24 hours after death To the Funeral Director: completely filled in by the f

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Union Memorial Hospita M1) 31. Date filed (Month, Day, Year) 32. Registrar's Signature 2007 JUL 0 9

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** Williams Robert Francis 2007 12:05 AM July 4, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel General Hospital Anne Arundel Co. Annapolis If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days **XX**M 2□ F Yrs Director 16,1934 Virginia 230-38-5038 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 ie marked other than "natural", or iteme 23a or 28a-f show traumatic event, "to Mudical Examenar nust be notified at 1 ☐ Yes 2 No Director Odenton Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2316 Station House Lane United States 21113 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Specify. Completed by 3 XWidowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Automobile Maintenance Auto Mechanic 6 Years 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any linjury or other traumatic event 9DGB. 18. Mother's Name (First, Middle, Maiden Sumame) Be Orville Williams Gracie Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Odenton, MD 2316 Station House Lane Stanley Williams (Son) 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State Sacred Ht. of Jesus Cem. 7/9/2007 Dundalk, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 Approximate Interval Between Onset and Death nt1. Enter the disease of mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure of tonly one cause on each line. Immediate Cause (Final **Physician** Due to (or as a consequence of): disease or condition resulting in death) tru /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed anding physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant been signed by the attenshould be detached for u 3 Ectopic pregnancy in the past 12 months? Dav 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 2 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral C To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

State Registrar

H

29b. Signature and

10

31. Date filed (Month, Day, Year)

title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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2001

32. Registrar's Signature

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

MO

medica

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Frank Lathem McAlwee

		1- For State Certif	ficate of	Death		, .	Reg	. No.	268	7 2.50
Physicia		Decedent's Name (First, Middle,Last)				Ιм	ate of Death lonth	Dav	Year	3. Time of Death 1033 hrs
Medical Exami	ner	FRANK L. MC ALWEE, III  4a. Facility Name (if not institution, give street and number)		b. City, Town, or L	acation of D		ne 29, 20	107	ounty of Death	1033 firs
		494 Keith Road	1	Lothian	ocation of D	eatri			ne Arundel	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last	birthday)	If Under 1 Year	If Under 24	Hrs. 8.	Date of Birth	MM/DD/	/YYYY) 9. Birth	nplace (State or
Director		212-17-0898   1XM 2 F   34	Yrs.	Months Days	Hours	Min.	5/30/	1973	Foreigr Cou	n Intry) MARY LAND
		Usual Residence of Decedent								
w any			own or Location	n						10d. Inside City Limits
Maryland 28a-f show 1 at once	tor	MARYLAND PRINCE GEORGE'S	UPP	ER MARLB	ORO	_ 41				1 Yes 2 X No
th the Maryland 23a or 28a-f she	Director	10e. Street and Number		10f. Zip Code			100		of What Coun	
after death with the Maryland al", or items 23a or 28a-f she nier must be notified at once		11560 DULEY STATION ROAD			20772				TED STA	
ath w	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces?		Decedent of Hisp s, specify Cuban,				14.	. Race - Americ White, etc.	ean Indian, Black,
fter de		1 Yes 2 XX No 3 Wildowed 4 XXDivorced If Yes, Give Yeer	1	Yes 2 X No	specify:			Spe	ecify: W	HITE
	d by	Lor Dates:	6a. Decedent	s Usual Occupation	on (Give kind		ione		of Business/In	ndustry
6 172 ha an "na cal Ex	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+)	· ·	st of working life. I		,				
5-0036 led within 72 Hygiene. other than the Medical	dmc		ELECTR	ICIAN AP					ELECTRI	CAL
	Be C	17. Father's Name (First, Middle, Last) FRANK L. MC ALWEE, JR.		17		,	t, Middle, Ma		rname)	
2121 ould be fil Mental H marked ic event,			19b. Mailing	Address (Street					or Town, State,	Zip Code)
ore, MD 2121 get and 2 should be file of Health and Mental If item 27 is marked ther traumatic event,		FRANK L. MC ALWEE, JR - FATHER	23530	AQUASCO	RD.,	AQUA	SCO, 1	MARY	LAND 20	0608
ore, Mes I and 2 of Health If item 2			ce of Disposit	ion (Name of cemer place)	etery,	Dat JULY		20c. Loc	ation - City or 1	Town, State
imore Pages I nent of H ant: If i or other		4 Donation 5 Other Specify: ST.		CHURCH	CEM	5, 2		AQU.	ASCO, M	IARYLAND
20a. Method of Disposition  1 XXBurial 2 Cremation 3 Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other place)  1 XXBurial 2 Cremation 3 Removal from State  4 Donation 5 Other Specify:  21. Signature of Funeral Service Licensee  22. Name and Address of Facility HUNTT FUNERAL HOME  23. Signature of Funeral Service Licensee  24. A COLOR ST. MARY S. CHURCH CEM 5, 2007 AQUASCO, MARY S. CHURCH C										
	_	Mout M. Jahren M0005  23a. Part I. Enter the disease, or complications that caused the death. Do	1000	5 OLD WA						
Physician /Medical		failure. List only one cause on each line.			uch as cardi	ac or resp	oratory arres	т, ѕпоск,	or neart	Approximate Interval Between Onset and Death
taminer		Immediate Cause (Final disease or condition resulting in death)  a Narcotic (heroin) in Due to (or as a consequence of):	intoxica	tion	_					Death
		Sequentially list conditions, b				0/3				
	iner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause								
ted I msit	Examin	events resulting in death) Last Due to (or as a consequence of):								9
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760, Teate be physical the buri	/Medical	IF FEMALE:   23c. If yes, outcome of pregnar	ncy			1		23d. D	ate of delivery	
ox 687 ath certific	cian/	23b. Was decedent pregnant in the past 12 months?  1 Live birth 4 Pregnant at time of death		al death 3	Ectopic pre	egnancy		Mo	onth D	ay Year
Box 68 e death certif the attending ed for use as	<u>ا تت</u>	1 Yes 2 No 9 Unknown g Unknown	5 Oth	er (Specify)						
that the detached	, Phy	Part II. Other significant conditions contributing to death but not resu	alting in the ur	derlying cause giv	ven in Part I.		23e. Did tob	acco use	contribute to t	he cause of death?
r, P.C	d by	Cocaine use				_	1 Yes	2 🗸 N	o 3 Proba	ably 4 Unknown
ords w requir	Completed					- 1	24a. Was ar autopsy			opsy findings available ompletion of cause of
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tal Rec	οl	25. Was case referred to medical			of Death (Ch	eck only o				
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J of Jing Ph After t	اق	1 Notural (Month, Day, Year)	8b. Time of In				Describe ho	w injury	occurred	
isior Attend or death rector: by the	läţi	2 Accident Pending Fnd 6/29/2007 F	nd 10:30	Janu	es 2 X No		ink			
Division of Vital Records, pital or Attending Physician: The law requireours after death.	Certification:	3 Suicide 6 X Could not be determined (Specify) House	e, farm, street	, factory, office bu	iliding, etc.		or Town, Sta	te)		al Route Number, City
. E S = E		29a. Certifier	death occurre	ed at the time date	e and place				Lothian	
Division To the Hospital or Attent within 24 hours after death To the Funeral Director:	Medical	one) 2 Medical Examiner: On the basis of examination and/								
F 3 F 8	Re	29b. Signature and title of certifier		29c. License	number		Т	29d. Date	e signed (Mon	th, Day, Year)
		Marpine The While		O.C.N	1.E.			June 3	30, 2007	
(0	Ī	30. Name and address of person who completed cause of death (Item 23	*	nn Ctroot De	Itimor-	1D 040	21			
NO St	ate	Margarita Korell MD. Assistant Medical Examiner 31. Date filed (Month, Day, Year) 32. Resistrar's Signature.		nn Street, Ba	iumore, N	10 2 12(	1			
Regist	rar	31. Date filed (Month Day, Year) 2 2007 32. Resistrar's Signature	Spo	de		_				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 2007 **Physician** 1030 A M July William David Beamer /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Cecil 140 Hilltop Road E1kton If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours Min. (Month, Day, April 9) 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F 1945 Maryland 214-74-6386 62 Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene.

is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Directo Maryland Ceci1 Elkton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21921 United States 140 Hilltop Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 【 No Specify Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced White 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Not Applicable Not Applicable permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If item 27 is marked othe any Injury or other traumatic event, once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gerald Elwood Beamer, Sr. Neva Carrie Dean ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 140 Hilltop Road, Elkton, Maryland 21921 Larry M. Beamer/Brother 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gilpin Manor 20a. Method of Disposition 20c. Location - City or Town, State July 5, 1 XBurial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 2007 Elkton, Maryland Memorial Park 22. Name and Address of Facility.
Hicks Home for Funerals, P.A.
103 W. Stockton Street, Elkton, Maryland 21921 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Due to (or as a construence of): /Medical Examiner Olinem a Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for sele consequence of Examiner Physician; The law requires that the death certificate be executed Povernona burial-tran Due to (or as a consequence of) attending physician Physician/Medical (3000) Myora the IF FEMALE nse : 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) the a 9 Unknown 9 Unknown ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy 2/ No 1∐ Yes 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 2 ER/Outpatient 3□ DOA Certification: To 1 Inpatient this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

Division or Vital Records, P.O. Box 68760, Hospital or Attending 24 hours after death e Funeral Director; completely within 24 2

Baltimore, Maryland 21215-0036

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

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MD

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HSU

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29c. License number

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29d. Date signed (Month, Day, Year)

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			For State	State of	Marylan		artment of I rtificate of		d Mental Hyg	Book Par		21940
			Ragistrar  1. Decedent's Name (First, Midd	le Last)		Cei	unicate of	Deain	2. Date of Dea	Rag. No.		3. Time of Death
	Physicia		Ethel Elizab		10				June	38	2 <b>0</b> 07	11:04P M
	/Medic Examin		4a. Facility Name (If not institution		<u> </u>		4b. City, Town,	or Location of E			nty of Death	
	LXamiii	CI	Homewood at	Williamspor	t		William	sport		Wash	ingtor	1
	Funeral		5. Social Separity Number	6. Sex 7	. Age (In yrs. I		If Under 1 Year Months Days		Hrs. 8. Date of Birt	h v. Year)	9. Birthp	lace (State or Foreign
	Director		210 <del>-06</del> -9163	1 ☐ M 2 🔀 F	103	Yrs.	Wioriais Days	1,0010	Min. (Month, Day May 15	1904		PA
	and w		Usual Residence of Decedent  10a. State 10b. Count	/	10c. City	, Town or Lo	cation				1	0d. Inside City Limits
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	the notif	Director	10e. Street and Number		.,,		10f. Zip Code			10g. Citizen o	of What Cour	ntry?
	h with		16505 Virgin	ia Avenue			21795				USA	
	deat	Funeral	11. Marital Status	12. Was Deced		S. 13.	Was Decedent of I	Hispanic Origin	? (Specify Yes or No- uerto Rican, etc.)		ace - Americ lack, White,	
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Ö	within 72 hours after death with the Maryland ane. Than "natural", or items 23a or 28e-f show is Medical Examinat must be notified at	ed by	3 ☑ Widowed 4 ☐ Divorce		es:	160 Dane	danda I lavel Occur		1			
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b	al Hyg I othe vent,	Bec	17. Father's Name (First, Middle	Last)					Name (First, Middle,	Maiden Sum	ame)	
<u>ya</u>	Ments Ments arked	To	Ferdinand S.	Gilbert				Etha	Hoffman			
Maryland 21215-0036	2 shot and the man		19a. Informant's Name/Relation	, , , , , ,	- 014				or Rural Route Numbe	•		
e,	1 and 1ealth 1 am 27 ther t		Jean B. Mille 20a. Method of Disposition	r daught		- Contract of the Contract of	LITTLE It sition (Name of	layden (	Circle, Ha	gersto 20c. Location		
ē	ages nt of l t: If it		1 Burial 2 ☐ Cremation		ate	emetery, crer	natory or other pla			Waynes		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Healih and Mental Hydiene.  Department of Healih and Mental Hydiene.  By injury or other traumetic event, the Medical Examinar must be notified at once.	1	<ul> <li>4 □ Donation 5 □ Other (</li> <li>21. Signature of Funeral Service</li> </ul>		GE		.11 Cem.			_		
B	permi Depa Impo any ir		Domes A	Breiloss	N/2		Grove-Bo	wersox	Funeral H Street, W	ome, I	nc. oro Pa	17268
	1.5		23a. Part Enter the disease, of shock, or heart failure. Lis	r complications that car	used the death						OLO 17	Approximate Interval Between
	Enysician :		Immediate Cause (Final disease or condition	A)	None	colo	oscr				,	Onset and Death
	/Medical		resulting in death)	a Due to (o	r as Toonsequ	ience of):	07(1				t	cuj.
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Вох	death certifi e attending p d for use as	M/u	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	ome of pregnath 2 Petal		Ectopic pregnanc			23d. E	Date of delive	*
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P.0	that the death	Physician/M	9 Unknown						00 - Did.			
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of		-	27. Manner of Death	28a. Date of		28b. Time of Injury		ry at	28d. Describe h			7
jo	Attending or death. ector: After by the fune	atio		igation	Day reary	пцагу		Yes 2 □ No				
Division	I or Atten after deat Director: I in by the	ertification;	3 Suicide 6 Could 4 Homicide determ	nined 289. Place of	f Injury - At ho g, etc. (Specify	me, farm, str	eet, factory, office		28f. Location (S City or Tow	Street and Nur m, State)	nber or Rura	l Route Number,
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	To the Hospital or Attenwithin 24 hours after deat To the Funerel Director: completely filled in by the	edical	29a. Certifier 1 Certifyi (Check only one) 1 Medical	ng Physician: To the b Examiner: On the bas and manne	is of examinat	wiedge, death ion and/or inv	estigation, in my	me, date and p opinion, death o	lace, and due to the coccurred at the time, o	cause(s) and r date and place	manner as st e, and due to	ated. the ca <i>u</i> se(s)
	thin thin mple	Med	29b. Signature and title of confi	77	i statou.		29c. Licen:	se number		29d. Date sign	ned (Month,	Day, Year)
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}	F ≥ E 8		1/1/1					Zaka	06	Sull	2	2007
			30. Name and Address Opersor	who completed cause	of death (US)n	23а) (Туре,	Print)	2680	06 .	July	2,	2007
	2	N.S.Y	30. Name of Odress of Dersor 31. Date filed (Month, Day; Year	10 1346	of death (US)	23a) (Type,	Print	2680 Aug	Twe Ha	July 1904	2,	2007 1021742

LAKHVINDER

31. Date filed (Month, Day, Year) JUN 25

Baltimore, Maryland 21215-0036

Medical Certification: To Be Completed by Physician/Medical Examiner

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For State Registrar						te of D		J 1V1	entarriy	Reg. N	9 11	07	2194
Decedent's Name (First,									<ol><li>Date of De Month</li></ol>		ay	Year	3. Time of Death
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a. Facility Name <i>(If not ins</i> Frederick M					1	,Town,orl ederi	ocation of De.	ath		Į.	c. County Frede		
. Social Security Number	6. Sex		Age (In yrs.	last birthday)	If Unde Months	er 1 Year Days	If Under 24 H Hours Mi	rs.	8. Date of Bir	rth	r)	9. Birth	place (State or Foreign
217-14-7706  Usual Residence of Deced		M 2   F	85	Yrs.	INOTALL	Dujo	TIOGIO IVII		(Month, Da March	28,	922	Mar	yland
Oa. State 10b. C			10c. Cit	y, Town or Lo	ocation		-						10d. Inside City Limits
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0e. Street and Number	<b>.</b>					p Code					itizen of W	_	
1711 W. 7th			5	0 40		21702		10	16.14		ited		ites
Marital Status     □ Never Married 2 □	Married	2. Was Decedo Armed Forc 1 X Yes 2 If Yes, Give	es?		Was Deci If Yes, sp	**	panic Origin? , Mexican, Pu <i>Specify:</i>	(Spe Jerto F	cify Yes or No Rican, etc.)	0-		k, White	ican Indian, , etc. hite
3 ☑ Widowed 4 ☐ Div	orced cedent's Educa		es: WW I		dent's Us	ual Occupat	ion			16b	Kind of Bu		
(Specify only	highest grade	completed)	(or F.)	i (Give	kind of w	ork done du use retired)	ring most of w	workin	ng		01 100	U33/II	
Elementary/Secondary (6	)-12)	College (1-4	-or 5+)	Secu	rity	Guard	i			U.:	S. Go	vern	ment
7. Father's Name (First, M	,						8. Mother's N	Vame	(First, Middle	, Maide	n Surnam	e)	
Washing	ton		Barnar	d			Julia		May		Jo	nes	
19a. Informant's Name/Re	ationship (Type	e. Print)		19b. Maili	ng Addres	s (Street ar	nd Number or	Rura	Route Numb	er, City	or Town,	State, Z	ip Code)
Sharon Reckl	ey / Da	ughter					ord Rd.		Frede				704
0a. Method of Disposition 1 ☐ Burial 2 ☐ Crem	ation 3 ⊟Re	moval from St	1 6	Place of Dispo cemetery, cre	osition (Na matory or	me of other place	)	D	ate	20c.	Location -	City or T	own, State
4 □ Donation 5 💢 Of		_		unt 01	ivet	Cem.	06/	27	/2007	Fre	deri	ck,	Maryland
23a. Part1. Enter the diseashock, or heart failure	gyal S	Pele ations that cau	sed the death	$\bigcup$ 1	.621	0possi	umtown	Pi		red			2 21702 Approximate Interval Between
Immediate Cause (Final disease or condition resulting in death)	a.	ASI	PIRAT as a consequ		ρ	NEUI	MONI	A					Onset and Death
Sequentially list conditions and the line of the line	b.		as a consequal	,									
	d.												
IF FEMALE: 23b. Was decedent pregna in the past 12 months 1 □ Yes 2 □ No 9 □ Unknown	ant p		h 2 ∏ Feta nt at time of d	I death 3	⊒Ectopic   ⊒ Other (≲	pregnancy specify)					23d. Date Mor		very Day Year
Part II. Other significant of ACUTE RE		_		ulting in the u	nderlying	cause giver	in Part I.						the cause of death?
SEPSIS								_	24a. Was	psy	_   P	rior to co	opsy findings available
									perfe 1 Yes	ormed? 2 2 N		eath? □Yes	2 No
<ol> <li>Was case referred to mexaminer?</li> <li>1 Yes 2 No</li> </ol>	<u> </u>	spital:	atient 2	ER/Outpatier	nt 3□ D	Othor			<i>(Check only i</i> ne 5 ☐ Resi		6 🗆 🗆	or (Sno-	(6.1)
7. Manner of Death 1 ☑ Natural 5 ☐ [	Pending	28a. Date of		28b. Time o Injury		28c. Injury Work?			8d. Describe				ny)
3 Suicide 6 □ (	nvestigation Could not be determined	28e. Place of building	finjury - At ho , etc. <i>(Specif</i> )	ome, farm, str			∠∐N0	2	8f. Location ( City or To	Street a wn, Sta	and Numbe te)	er or Rui	ral Route Number,
29a. Certifier 1 ☐ Ce (Check only one) 2 ☐ Me	ertifying Physic edical Examine	cian: To the ber: On the bas and manne	is of examina	wledge, deat tion and/or in	h occurre	d at the time n, in my opi	e, date and pla nion, death o	ace, a	and due to the	cause( , date a	s) and mai nd place, a	nner as and due	stated. to the cause(s)
9b. Signature and litle of	ertifier MD					DOG	3498				ate signed		, Day, Year) 3007
30. Name and address of p		pleted cause	of death (Item	23a) (Type.	Print)								

Registrar

400 West Seventh St./ Frederick, MD

21701

DHWN, MD 32. Jegistrar's Signature

WADHWA,

2007

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Richard C. Boys 2Ó 6:05 Αм June 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Heron Point Chestertown Kent 8. Date of Birth (Month, Day Year) Jan. 20, 1913 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Min **X**M 2□ F 94 Director 245-60-9780 Yrs. Canada Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "natural", or items 23a or 28a-1 show the Medical Examiner must be notified at Maryland Kent Chestertown 1 Yes 2 XNo Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 133 Heron Point 21620 U.S.A. filed within 72 hours after death Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 1 XYes 2 No If Yes, Give 1935–65 Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: Specify. þ 3€Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Colonel U.S. Air Force 5+ other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental int: If Item 27 Is marked o Robert W. Boys Elizabeth Waring or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5037 Three Kings Lane Columbia, Maryland Richard C. Boys, Jr./son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department Important: If any injury o 1 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Crematory 6/22/2007 Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Carenna **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (uisease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☑ No 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident rector: the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by after 4 Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29b. Signature 50060301 of death (Item 23a) (Type Print) Ab SAS CHESTER TOWN M) EIMER NO michines 31. Date filed (Month

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1-For State 6-29-07Ameno#1 - PerM-DPG or Registrar Ameno#7 - PerFHPO06-25-07cm Certifica	ate of Death		. No.	
ledi	Physic ical Exam			ir.	2. Date of Death Month D June 20, 20	Day Year	3. Time of Death 1457 hrs
			4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	1407 1113
			6317 Macaw Court	Elkridge		Howard	
1	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birth 123-58-3232 1 M 2 F 50 50	thday) If Under 1 Year If Under 24Hrs Months Days Hours Min Yrs.		(MM/DD/YYYY) 9. Birth Foreigr 9.5.7 Cou	nplace (State or n ntry) Guyana
	any		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town	or Location			10d. Inside City Limits
	Maryland 28a-f show any 1 at once.	٦	Md. Howard Laure	:1			1 X Yes 2 No
	Maryland 28a-f sho d at once.	Director	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Coun	try?
	th the ] 23a or aotifie			20723		U.S.A.	
	IIIOTE, INID ZIZIS-UUSO Pages 1 and 2 should be filted within 72 hours after death with the Maryland cet of Health and Mental Hygiene. Itiem 27 is marked other than "natural", or items 23a or 28a-f she unit. If item 27 is marked other than "natural", or items 20a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 X Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No	13. Was Decedent of Hispanic Origin? (Spilf Yes, specify Cuban, Mexican, Puerto		14. Race - Americ White, etc.	
	rs after ural", miner	à		1 Yes 2 X No specify:		y-	ack
	72 hour n "nat al Exa	eted	Elementary/Secondary (0-12) College (1-4 or 5+)	Decedent's Usual Occupation (Give kind of v during most of working life. DO NOT use reti		6b. Kind of Business/In	dustry
5.0038	ed within 7 tygiene. other than	Completed		ruck Driver		Sand-P T	rucking
215.0	e, INID ZIZIS-UUSO I and 2 should be filed within 72 Health and Mental Hygiene. item 27 is marked other than ir traumatic event, the Medical	ပ္ပ			e (First, Middle, Mai	,	
2	A LLI hould be fil and Mental F is marked tic event,	To Be		b. Mailing Address (Street and Number or I	ed G10	oria Neil: er, City or Town, State.	S Zin Code)
2	e, MD I and 2 she Health and item 27 is	1	Sandra Ramona Britton-wife 9!	524 Odelton Ct.,	Laurel,	Md. 207	23
o'L	of Hea		20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State cremator	of Disposition (Name of cemetery, ory or other place)		20c. Location - City or T	
Ralfimore	t. Page tment rtant: y or of		4 Donation 5 Other Specify: Maryl			Laurel,	
Ra	DCAILLINGTED permit. Pages 1 Department of H Important: If i		24 Signature of Funeral Service Licensee	22. Name and Address of Facility Ur	niversal	Mortuar	У
P	Physician		23a. Part I. Enter the disease, or complications that caused the death. Do no	411 Kennedy St., of tenter the mode of dying, such as cardiac of	NW Wash	nington, D , shock, or heart	Approximate Interval
	/Medical Examiner		failure. List only one cause on each line. Immediate Cause (Final disease a. Multiple Injuries				Between Onset and Death
	-Acimi		or condition resulting in death)  Due to (or as a consequence of):				
		ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
		Examiner	cause. Enter Underlying Cause (Disease or Injury that Inhiared events resulting in death) Last  Due to (or as a consequence of):				
	recuted n and r transit		d				
_	cate be exe physician a	Medical	UNPENDED AMENDED				
8760			IF FEMALE: 23b. Was decedent pregnant in the 2. Live birth 2.	Fetal death 3 Ectopic pregna	2221	23d. Date of delivery  Month Da	Voor
Box 68	eath certific attending	sicia	past 12 months?  2 4 Pregnant at time of death 5		IIICy	Month Da 	ay Year
	hec he	Physician/	Part II. Other significant conditions contributing to death but not resulting	g in the underlying cause given in Part I.	23e Did toba	cco use contribute to the	- sever of death?
PO	S 50 0	<u>ج</u>	Continuing to depart part not resulting	) in the underlying cause given in Fact i.		2 ✓ No 3 Proba	
Sp	ing Physician: The law requires that After this certificate has been signed funeral director, page 2 should be dete	Completed		· · · · · · · · · · · · · · · · · · ·	24a. Was an	24b. Were auto	ppsy findings available
eco	he law ate has age 2 s	dmo			autopsy performe 1 ✔ Yes 2	ed? death?	mpletion of cause of
al R	an: T ertifica ctor, pr	امها	25. Was case referred to medical	26.Place of Death (Check		No 1 ✓ Yes	2 No
ΓVit	ding Physician: The l	To B	110 163 2 140			sidence 6 Other:	Scene
Division of Vital Records.		ation:	27. Manner of Death  1 Natural 5 Pending 2 ✓ Accident Investigation  28a. Date of Injury (Month, Day Year) Jun 20, 2007  1450	Fime of Injury 28c. Injury at Work?  1 ✓ Yes 2 No	28d. Describe how Pedestrian str		
Divis	To the Hospital or Attend within 24 hours after death To the Funeral Director:	Certification:		rm, street, factory, office building, etc.	28f. Location (Stre or Town, State 6317 Macaw Cou	eet and Number or Rura e) urt, Elkridge, MD	Route Number, City
	e Hosp 1 24 ho e Funt letely f		29a. Certifier Check only 1 Certifying Physician: To the best of my knowledge, deal	th occurred at the time, date and place, and	due to the cause(s	and manner as stated	
	To th within To th comp	Medical	one)  2 Medical Examiner: On the basis of examination and/or in and manner spoted.				
		2	29b. Signature and title officertifie	29c. License number O.C.M.E.		9d. Date signed <i>(Mont</i> i June 21, 2007	h, Day, Year)
1			30. Name and address of person who completed cause of death (Item 23a)	0.0.IVI.L.		June 21, 2007	
P			Susan Hogan MD. Assistant-Medical Examiner 11	1 Penn Street, Baltimore, MD 213	201		
	St	tate	31. Date filed (Month Par Year) 32. Registrar's Signature	,			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death June 20,2007 **Physician** Priscilla Keneagy Bowes 10:30am м /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 12214 Maycheck Lane Prince George's Rowie 8. Date of Birth (Month, Day, Year) OCt. 23, 1937 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** Days Months Hours Min 1 □ M 2 🗙 F 192-30-7473 69 Kinzer, PA Director Usual Residence of Decedent filed within 72 hours after death with the Maryland show 10a, State 10h. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at Director 1 ☐ Yes 2 ☑No MD Prince George's Bowie 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 12214 Maycheck Lane 20715 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🗷 No Specify: Completed by 3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nassa-GFSC Information Technology item 27 is marked other other traumatic event, i 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be fill timent of Health and Mental H tant: If item 27 is marked oth Be Harold B. Keneagy Roberta Eckman ۵ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maurcilla Kay Bowes /Daughter 12214 Maycheck Lane, Bowie MD 20715 June 22, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State = ১ permit. Page Department of Important: If any Injury or Arligton, VA 4 □ Donation 5 □ Other (Specify) 2007 Metropolitan Crematory 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy.Bowie,MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final E123,4,1 Physician disease or condition resulting in death) /Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine law requires that the death certificate be executed burial-tran Due to (or as a consequence of): physician Physician/Medical the IF FEMALE for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗙 No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) the 9□ Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a, Was an certificate has page 2 autopsy performed? 2 ☐ No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 2☑ No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 5 Residence 6 □Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After 28d. Describe how injury occurred or Attending 1 Natural 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Division or Vital Records, P.O. Box 68760,

Baltimore,

within 24 hours a State

Vadel 31. Date filed (Month, Day, JUN 2 5 2007



and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certif

Medical

000

11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 22 June 2007 6:41 A M Joseph Charles Baumann 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov. 22,1921 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Min. 1 M M 2 □ F Months Hours 577-28-6314 85 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐Yes 2√ No Anne Arundel Crownsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1200 Severnview Drive 21032 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1X Yes 2 □ No If Yes, Give Year or Dates: WW II 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: White Specify 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Prince George's Elementary/Secondary (0-12) College (1-4or 5+) County Govt. Investment Chief 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Herman Baumann Frances M. Maener 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arlington, VA. Patricia J. Baumann/dau. in law 5829 25th Rd. North 22207 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Furial 2 ☐ Cremation 3 ☐ Removal from State 06/26/2007 | Adelphi, MD. 4 Donation 5 Other (Specify) Geo. Wash. Cemetery 21. Signature of Funeral Service License 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy. Bowie, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Oulseless electrical disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) □Yes 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an 1⊟ Yes 2ENO 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Hospital: Inpatient 2 ER/Outpatient 3 DOA

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

10a. State

MD

Director

Funeral

2

Completed

Be

2

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event; the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

burial-transit

physician s the burial Jas page certificate this After t

The law requires that the death certificate be executed

Box 68760.

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Division or Vital Records, P.

Physician/Medical Completed by

Examiner

Be Certification: To

within 24 hours after death.

To the Funeral Director: A completely filled in by the fi

Hospital or Attending

DHMH 17 Rev 1/2001

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

29b. Signature and

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 ☐ Yes 2 ☐ No

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 6-22-07

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5 Pending investigation

6 ☐ Could not be

28a. Date of Injury (Month, Day Year)

and manner stated

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2007 July 3, 9:15 AM Catherine Elizabeth Crabbs /Medical County of Death
Frederick 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Northampton Manor Nursing Home Frederick 8. Date of Birth Juneth, **24**, Yea**1**916 If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. Social Security Number 9. Birthplace *(State or Foreign* MaryLand 6. Sex Age (In yrs. last birthday) **Funeral** 91 214-10-1119 1 □ M 2**X**□ F Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must he natified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Frederick Frederick 1 ☐ Yes 2 No Directo 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 8923 Yellow Springs Road 21702 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 Mo If Yes, Give Year, or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2XXNo Specify White à Specify: 3 Widowed XXDivorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harvey Schwearing Cora Hargett ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carroll L. Crabbs, son 10329 Old Annapolis Road, Walkersville, MD 21793 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Entonoment Mount Olivet Cemetery July 6, 2007 | Frederick, MD 21. Signature of Funeral Service License Reeney and Bastord PA Funeral Home MO0255 106 East Church St., Frederick, MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PULMONARY DISEASE **Physician** CHRONIC DBSTRUCTIVE MONTHS-45A /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and sthe burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 4☐Pregnant at time of death Day 5 Other (specify) 9 Unknown signed by the detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ဥ 1 | Yes 2 → No 1 ☐ Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, within 24 hours after death

To the Funeral Director:
completely filled in by the

Baltimore, Maryland 21215-0036

State Registrar

10

Medical

29a. Certifier

one)

(Check only

29b. Signature and

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MO

Ronald E. Miller, M.D., 4 Culwell Drive, Mt. Airy, Maryland 21771

1 FCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D 26499

29d. Date signed (Month, Day, Year)

July 3, 2007

			For State Registrar	State of M	Maryland /		artment rtificate			ind Me		jiene	007	2 (5)
	Physici	an	1. Decedent's Name (First, Middle, La								2. Date of Dea _Month	th Day	Year	3. Time of Death
1	/Medic	al	Mary E. Cummings 4a. Fecility Name (If not institution, gi		ar)		4b. City. T	Town, or	Location o		June	20 de. C	2007 County of Death	05:50A M
	Examin	ler	Spa Creek Center				Anna						ne Arund	lel
	Funeral Director		214-54-2066	Sex 1 □ M 2 T F	Age (In yrs. last b 92	virthday) Yrs.	If Under 1 Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birth (Mooth, Day 03/17/	1915	9. Births Cow Kent	place (State or Foreign ntry) Lucky
	yland yland		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	wn or Lo	cation						1	0d. Inside City Limits
	Sa-f st	ctor	Maryland Anne Ar	undel	Mayo									1 ☐ Yes 2 📉 No
	3a or 2	Dir	10e. Street and Number 1683 Cliff Drive				10f. Zip (				1		en of What Cour Lted Sta	
92	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Heelih and Mental Hygiene. Important: If term 27 is marked other than "natural", or tems 23a or 28a-f show important: If term 27 is marked other than "natural", or tems 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.	by Funeral Director	11. Marital Status  1 Never Married 2 Married	12. Was Deceder Armed Force 1  Yes 2 If Yes, Give	2 1 1 1 1 1	1	Was Deceder f Yes, spect		spanic Orig n, Mexican Specify:	jin? (Spec , Puerto R	ify Yes or No- lican, etc.)		I. Race - Americ Black, White,	etc.
00	2 hours atural', cal Ex	ed b	3 Widowed 4 Divorced  15. Decedent's E	Year or Date:		a. Deced	ient's Usual	Occupa	ation				Specify: Whi	
215	ithin 72 18. 18n "na 1. Marik	Completed	(Specify only highest gr Elementary/Secondary (0-12)	rade completed)  College (1-4c	or 5+)	(Give lite. L	kind of work DO NOT use	k done d e retired	luring most )	of working	g			
121	iled wi Hygien ther th		17. Father's Name (First, Middle, Las	2	Co	rpor	rate 0	ffic		rte Namo	(First, Middle,		structio	n
lanc	lid be f fental f rked of	To Be	Earl F. Wright	.,							khead	Maiden S	umame)	
Maryland 21215-0036	2 should and he le main	3	19a. Informant's Name/Relationship										Town, State, Zip	Code)
ē,	tem 27 tem 27 tem 27		Wesley C. Whitelo 20a. Method of Disposition		20b. Place	of Dispo.	sition (Name	e of		Mayo,	Mary 1		21106 ation - City or To	own, State
imo	Pages nent of ant: If I ury or o		1	□Removal from Sta fy)	te Mayo U.	•	natory or oth nurch Co		' 1	6/25	/2007	Mavo	, Maryl	and
Baltimore,	permit. Departr Importa		21. Signature of Minutal Pervice Ice	nsee		22	. Name and	Addres	s of Facility	Geo:	rge P.	Kala.	s Funer ter, MD	al Home
			23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final	nplications that caus one cause on each	ed the death, Do	not ente	er the mode	of dying	g, such as o	cardiac or	respiratory arr	est,		Approximate Interval 8etween Onset and Death
	Physician /Medical		disease or condition resulting in death)	a Due to (or a	as a consequence	RCU	aC	#	4410	MIC	^ '			
	Examiner	_	Sequentially list conditions,	b										
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Erner Underlying Cause (Disease or injury that initiated events		as a consequence	e or):								
90,	ate be executed only sicien and the burial-transit		resulting in death) Last	c. Due to (or a	as a consequence	∍ of):								
68760,	ficate t physic is the b	edica		_ d.										
P.O. Box	that the death certificated by the ettending potential detached to use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal deat at time of death		Ectopic pre Other (spe					23	d. Date of delive Month	er <b>y</b> Day Year
	9 5 6	Ď	Part II. Other significant conditions	contributing to death	but not resulting	in the ur	nderlying ca	use give	n in Part I.					ne cause of death?
Division of Vital Records,	: The law requicate has been ; page 2 should	Completed									24a. Was a autops perform	in Sy media 20 No	death?	psy findings available mpletion of cause of 2 No
<u> </u>	sician: The certificate	o Be	25. Was case referred to medical examiner?  1 Yes, 2 Yo	Hospital: 1  Inpa	tient 2 ER/C	en etian		Othe			(Check only on		☐Other (Specif	
n of	Attending Physician: r death. ector: After this certifica by the funeral director;	on: To	27. Manner of Death  1 Natural 5 Pending	28a. Date of Ir		Time of		c. Injury Work	420 1401		d. Describe ho			у)
isio	death. ctor: A	catle	Accident investigation	on 28a Place of l			М	1 🗆 \	res 2□N		M Leasting (C)		N	10
2	s after death	Certification:	4 Homicide determined	building,	njury - At home, etc. (Specify)	rarm, stre	eet, factory,	office		28	City or Town	reet and i n, State)	Number or Hura	ul Route Number,
	Hospi 4 hou Funar ely fill	edical	29a. Certifier (Check only one) Certifying P	hysician: To the be- miner: On the basis and manner	of examination a	ge, death nd/or inv	occurred a restigation, i	t the tim in my op	e, date and inion, deat	place, an	nd due to the ca d at the time, d	ause(s) ar ate and p	nd manner as s lace, and due to	tated. o the cause(s)
)	To the To the To the Complet	Σ	29b. Signature and title of certifier				29c.	License	number 57C	28	2	9d. Date	signed (Month,	Day, Year)
C	D 4		39. Name and address of person who	1 MD 1	100 R	A P	Print) Ply	ANE	- Ar	maj	polis,	MD	. 214	01
徐	Sta Registra		31. Date filed (Month, Day, Ydar) JUN 2 1	2007 32. Rev	strar's Signature	k	book				•			

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No 111. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year 31 /Medical 0 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number If Under 1 Year Months Days If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign
Country) Months 1 M 2 □ F Hours 216-05-2572 91 Director 30, Oct. 1915 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f ehrom any injury or other traumatin and injur 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Anne Arundel Annapolis Director 1 ☐ Yes 2 Theo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6105 River Crescent Drive 21401 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 157¥es 2 □ No If Yes, Give Year or Dates: 1940–45 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√€No þ Specify: Specify: 3 ₩ Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Banker 4 Banking and Securities 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Garnett Y. Clark Helen Hunt ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Clark Pratt/daughter 168 Thornton Dr., Palm beach Gardens, FL 33418 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2XX remation 3 ☐ Removal from State Ft. Lincoln Crematory 6/23/2007 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature of Fungral Service Licensee oda 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Securities if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE: lf yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Munch Completed ate has bage 2 s 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autonsy certificate 2 No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ဥ 1 🗌 Yes 1 NInpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Date of Injury 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 ☐ Pending investigation (Month, Day Year) 1 Natural 2 ☐ Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and magner stated. 29b. Signature and title of certifler 29c. License number

To the Hospita within 24 hours
To the Funeral completely filled

State Registrar 31. Date filed (Month,

DHMH 17 Rev 1/2001

DEFENSETIGAN AY ANNAPOLY

Name and address of person who competed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For CCHD DB State RegistrarAmend #26 Pre PHYS 6/22/07 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. 'Time' of Death **Physician** EMMA NOVELLA COLBERT JUNE 21, 6:00 AM 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 545 ROUND TABLE DRIVE FORT WASHINGTON PRINCE GEORGES If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Months Days Hours Min. FTBRUARY 23, 1918 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 💢 F 89 Yrs. 217-12-2954 MARYLAND Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 Yes 2 No Director MARYLAND PRINCE GEORGES FORT WASHINGTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r Items 23a or 2 12309 LIVINGSTON ROAD 20744 UNITED STATES Funeral death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black. White, etc. Pages 1 and 2 should be filed within 72 hours after and Mental Hygiene. 1 X Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 ò 1 ☐ Yes 2 No þ Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 'natural", the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 4TH GRADE SECRETARY FEDERAL GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental WILLIAM THOMAS CATHERINE WARRICK ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 l CHRISTINE B. COLBERT / NIECE 25 PARK SQUARE COURT, INDIAN HEAD, MARYLAND 20640 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages Department of Important: If Its any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State RESURRECTION CEMETERY JUNE 30, 2007 CLINION, MARYLAND 4 Donation 5 Dother (Specify) 21. Surfature of Funda Senta Licensocku 22. Name and Address of Facility LADIA C. THORNION JOHNSON MO0583 THORNTON FUNERAL HOME, P.A.
3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Da disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Exami and bunal-tran Due to (or as a consequence of): P.O. Box 68760. physician s the burial certificate be Physician/Medical as attending IF FEMALE: use If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached t Yes 2010 9□ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has certificate 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Family Other: 4 Nursing Home 5 Pesidence 6 X Other (Specify) Member 1 ☐ Yes 201No Hospital: ပ 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: Injury Natural 5 ☐ Pending investigation within 24 hours after death,

To the Funeral Director: Af
completely filled in by the ful 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital 🕰 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year)

1MIR

JUN 2 2 2007

use of death (Item 23a) (Type, Print) 32. pgistrar's Signature

MM

MD

46046

11711 LIVINGSTON Rd. FORT

			For State Registrar	State of M	aryland / Depa	artment of H			ene	1	210	5
			Decedent's Name (First, Middle, Las	t)				2. Date of Death	1		3. Time of	Death
	Physici /Medic		Nathanie1	В.	Chapman	Sr.		June	19 20	Year 07	9:44	а м
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death		4c. County of	of Death		
			1200 Elsa Avenue			Landove	r		Princ	ce Ge	orges	
	Funeral		Social Security Number 6. S		ge (In yrs. last birthday)	If Under 1 Year		8. Date of Birth			ace (State o	r Foreign
	Director		142-34-4493	M 2□F	60 Yrs.	Months Days	Hours Min.	(Month, Day, Oct. 19			$\frac{y}{y}$	
	P .		Usual Residence of Decedent									
	show	_	10a. State 10b. County		10c. City, Town or Lo	cation				10	Od. Inside Ci	•
	Be-f	5	MD PRINCE O	EORGE'S	Landove	<u> </u>					1 🗓 Yes	2 L NO
	हैं। 9 2 3	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of W	hat Count	try?	
	23a	rai	1200 Elsa Avenue			20785			U.S.A.			
	tems	Funerai	11. Marital Status	<ol><li>Was Decedent Armed Forces?</li></ol>		Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (Spe n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		- America		
36	or i	by Fi	1 Never Married 2 Married	1 ☐ Yes 2 ☑ If Yes, Give	No	1 ☐ Yes 2₺ No	Specify:		Specify:		Lack	
8	within 72 hours after death with the Maryland ene. than "naturel", or items 23a or 28e-f show than "naturel Examination and the invitite Jul	d b	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	140- 8							
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72	withii ane. than	m	Elementary/Secondary (0-12)	College (1-4or	5+)	ntenance/	•		Priv	iate		
9 9	Hygir ther ther		17. Father's Name (First, Middle, Last)		ETC: L	icenanice).	18. Mother's Name	(First, Middle, M				
an	d be antal	o Be	1.00	apman Sr		i	Myrt1		ckson	,		
Maryland 21215-0036	mark mati	은	19a. Informant's Name/Relationship (7			ig Address (Street a			City or Town S	State Zin	Code)	
S	mit. Pages 1 and 2 should be Ilied within 72 hours after death with the Marylan Department of Health and Menth Hygiene. Department of Health and Menth Hygiene. The marked other than "naturel", or items 23a or 28e-f show any injury or other treumatic event. It is wasted Examination in the modified at Once.		Nathaniel B. Chap			Elsa Ave				2078	_	
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<u></u>	ages int of t: It is		1 Burial 2 ☐ Cremation 3 ☐			natory or other place	' 1	1	CLINTON	-		
Baltimore,	int. P		4 Sonation 5 Other Specify 21. Signature Timeral 5 rvice Lice.	L	The second secon	. Name and Addres		B. Jenk		-		
Ba	Dep Impo		The signal of th			7474 Land					2078.	5
	-	_	23a Part1 Enter the disease or comm	lications that cause							Approximate	
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final						o.,		Interval Bety Onset and D	ween
	Physician Wedical		disease or condition resulting in death)	a	trointesti	nal Bleed	ing					
	Examiner	1			a consequence of):	11102						
		-	Sequentially list conditions,	D	rhosis of I	rrver						
	nsit	nin ni	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		atitis C							
	xecu a and	Examiner	that initiated events resulting in death) Last	C	a consequence of):					-		
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dicai E	· ·	4								
687	ficate phy: s the	edic	200	d								
Вох	eath certific attending p	N N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome					23d. Date	of deliver	rv	
m	death atte	ician/M	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a		Ectopic pregnancy Other (specify)			Mont			/ear
o.	that the de led by the a detached i	Physi	9 Unknown	9□ Unknown								
٣.	res that igned b be deta	by Pi	Part II. Other significant conditions co	entributing to death b	out not resulting in the u	nderlying cause give	en in Part I.	23e. Did toba	acco use contril	bute to the	e cause of d	eath?
g	n sign							1 ☐ Yes	2 🖾 No 3	3 🗌 Proba	abiy 4 ⊟U	Jnknown
Records,	w requires been si should I	Completed						24a. Was an	24b. W	ere autoc	sv findings a	available
æ	The lay ate has page 2	mc						autopsy perform	ed? de	ath?	sy findings a apletion of ca	ause of
_	10 14	e C	25. Was case referred to medical				OC Place of Death			☐Yes 2	2163 No	
	Physicien: this certific ral director,	OB	eyaminer?	Hospital: 1 ☐ Inpatie	ent 2□ER/Outpatien	t 3 DOA Othe	26. Place of Death	ne 5 DiResider		r /Cassife	)	
	y Phy or this oral c	$\vdash$	27. Manner of Death	28a. Date of Inju	ry 28b. Time of	28c. Injury	at 2	28d. Describe how			,	
0	nding I ith. : After s funer	ig I	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	y Year) Injury	Work M 1 □ Y	? /es 2.⊟No					
Division	l or Attending after death. Director; After in by the fune	ifica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Inj	ury - At home, farm, stre	et, factory, office	1	28f. Location (Stre		r or Rural	Route Numi	ber,
	el or A s after il Dire id in by	Certification;	4 Homicide	building, et	c. (Specify)			City or Town,	State)			
	To the Hospitel or within 24 hours afte To the Funerel Dir completely filled in		29a. Certifier 1 Certifying Phy	sician: To the best	of my knowledge, death	occurred at the tim	e, date and place, a	and due to the car	use(s) and man	ner as sta	ated.	
	To the Hos within 24 h To the Fur completely	edicai	(Check only 2 Medical Exam	iner: On the basis o and manner st	f examination and/or invated.	restigation, in my op	pinion, death occurre	ed at the time, da	te and place, ar	id due to	the cause(s)	1
	To the within 2 To the complet	Me	29b. Signature and title of certifier	~0	100	29c. License	number	29	d. Date signed	(Month, E	Day, Year)	
			> Dudh Un	outiti	~4)	D45	490		June 22	2, 20	07	
0	(2)		30. Name and address of person who o		leath (Item 23a) (Type,	Print)						
K			Dr. Yudh Gupta M	.D. 3001	Hospital I	rive, Che	everly. M	aryland	20785			
	Sta	te			ar's Signa							
	Registra	ar '	JUN 2 5 ZUUI	Teres D	. Upares							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav Month OUUT M **Physician** 0 WILLIAM /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Annapolis Anne Arundel Anne Arundel Medical Center If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5 Social Security Number 7. Age (In vrs. last birthdav) 8. Date of Birth (Month, Day, Year) **Funeral** THM 2□F Months Days Hours Min Yrs. Titusville,PA Director 208-14-3898 Sept. 15, 1928 Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notifled at 1 ☐ Yes 2 XNo Director MD Prince George's Bowie 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 3607 Melfa Lane 20715 USA by Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo White Specify Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than College (1-4or 5+) Elementary/Secondary (0-12) Super Markets Produce Manager other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be O'Brien Marion John N. Cartney ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 s ment of Health an Department of Health a Important: If item 27 is any Injury or other trau Once. 3607 Melfa Lane Bowie, MD 20715 Carolyn E. Cartney / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition June 25,2007 1 Burial 2 □ Cremation 3 □ Removal from State 5 Other (Specify) Davidsonville,MD 4 ☐ Donation Lakemont Mem. Gardens 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Highway Bowie, MD 20715 plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complicate shock, or heart failure. List only one of Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examine The law requires that the death certificate be executed ng physician and as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 DEctopic pregnancy Month in the past 12 months? Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a ☐Yes 2☐No 9□Unknown 9 Unknown been signed by to should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tohacco use contribute to the cause of death? þ 4 Unknown 1 TYes 2 □ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy this certificate 1□ Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Certification: To Be Other: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation Injury 1 Yes 2∏No nours after death.

neral Director: A
filled in by the fu 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Hospital within 24 hours To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number eted cause of death (Item 23a) (Type, Print) EFENSE M 32. Registrar's Signatu State

DHMH 17 Rev 1/2001

Registrar

DHMH 17 Rev 1/2001

State

Registrar

MICHAEL

31. Date filed (Month, Day, Year)

JUN 2 5 2007

FEA

MAM

32. Registrar's Signature

1-04/52		Please Type or Print in Black Indelible Ink. Ensure All Copie		ble.	
rian K. Complo		State of Maryland / Department of Health and Mental Hy	ygiene	2 1 1	7 2195
		Registrar Certificate of Death	Reg.		1 6120
Physicia		Decedent's Name (First, Middle,Last)	Date of Death     Month	Day Year	3. Time of Death
ledical Exami	ner	Brian K. Comploier	June 22, 200	07	0245 hrs
		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  Southern Maryland Hospital  Clinton		4c. County of Death	
				Prince George	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs Months Days Hours Min.		MM/DD/YYYY) 9. Birl Foreig	n
Director		220-17-1986   1X M 2 F   32 Yrs.   1	June 18,	, 1975 Co	<sup>untry)</sup> Wash., D.
* ************************************	45.000	Usual Residence of Decedent         10a. State         10b. County         10c. City, Town or Location	<u></u>		10d. Inside City Limits
* .		700.013) 100.01	•		1 Yes 2 X No
Aaryland 28a-f show 1 at once.	햦	MD Anne Arundel Crofton  10e. Street and Number 110f Zin Code	140	000	
th the Maryland 23a or 28a-f sho notified at once.	Director	18.12.5	10g.	. Citizen of What Cour	itry?
ith th		1107 Simsbury Court 21114		USA	
ath w items	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married 2 Married 2 Married 2 Married 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp. 15 Yes, specify Cuban, Mexican, Puerto		14. Race - Ameri White, etc.	can Indian, Black,
er de		1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify:	:	Specify: Wh	ite
hours aft	by	or Dates:  15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of v	vork done	6b. Kind of Business/I	
2 hou "nat	eted	Elementary/Secondary (0-12) College (1-4 or 5+)		ob. Nind of Dusiness/	idustry
336 thin 72 than than edical	omple	12 Heavy Equip. Operator		Construc	tion
5-0036 Tiled within 72 Hygiene. d other than *	S		(First, Middle, Mai		C1011
215 be file ntat H rked	Be	Frank F. Comploier Dolores	Mae Rule	eman	
Ould ould A Me	ဥ	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or F			, Zıp Code)
nore, MD ages 1 and 2 sho ant of Health and nt: If item 27 is		Dolores M. Comploier/mother 1107 Simsbury Court	Croftor	n, MD. 2	1114
Fe, s l an fifter er tra		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 2	20c. Location - City or	Town, State
Pages		1 25 Daniel E Occination of Internoval Iron State	27/2007	Brentwood	, MD.
Baltimore, permit Pages 1 ar Department of Hee Important: If ite injury or other tr		Total Company		eral Nome	
W EV TIE	d d	Chran lowell 6512 NW Crain Hwy.	Bowie,		715
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of failure. List only one cause on each line.	r respiratory arrest	t, shock, or heart	Approximate Interval Between Onset and
/Medical Examiner	Y 9	Immediate Cause (Final disease a. Multiple Gunshot Wounds			Death
to mention		or condition resulting in death)  Due to (or as a consequence of):			
	<u>~</u>	Sequentially list conditions, if any, leading to immediate			
	Ë	Course Enter Universitying Course (Disease or injury that initiated			
sd sit	Examiner	events resulting in death) Last Due to (or as a consequence of):			
executed an and al - transit	ical	d			
<u>a a a</u>	ğ	UNPENDED			
Box 68760, edeath certificate be the attending physici d for use as the buri	sician/Med	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnance		23d. Date of delivery	
K 68	cia	past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnar 4 Pregnant at time of death 5 Other (Specify)	incy	Month [	Day Year
BO) e deatl the att	Physi	1 Yes 2 No 9 Unknown 9 Unknown			
ires that the signed by		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		acco use contribute to	
ires th	d by		1 Yes	2 No 3 Prob	ably 4 Unknown
rds requ	Completed		24a. Was an autopsy		topsy findings available completion of cause of
eco he law ite has	Ĕ		performe	ed? death?	_
tal Rection: The	S C	25. Was case referred to medical 26.Place of Death (Check		No 1 ✔ Ye	s 2 No
Vita hysicia this ce	<b>20</b>	examiner?		esidence 6 Other	
Division of Vital Records, P.O. Box 68760, Nopital or Attending Physician: The law requires that the death certificate be 24 hours after death.  Per certificate his been signed by the attending physicienteral Director: After this certificate has been signed by the attending physicientely filled in by the funeral director, page 2 should be detached for use as the bur	 To	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?	28d. Describe hov		
On tendin sath. or: A	ij	pending 5 No 1 Yes 2 No	Subject shot		
Division lal or Attendi rs after death.	fica	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (Stre	eet and Number or Ru	ral Route Number, City
pital o	Certification:	4 ✓ Homicide (Specify) Parking lot	or Town, Stat 5753 Crain High	te) nway, Upper Marlbo	ro, MD
Divisior Bospital or Attend 24 hours after death Funeral Directorsetely filled in by the	al C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and	due to the cause(s	s) and manner as state	ed.
Division To the Hospital or Attend within 24 hours after death To the Funeral Director:	ledical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a and manner stated.			
	Me	29b. Signature and title of pertifier 29c. License number	2	29d. Date signed (Mo	nth, Day, Year)
Char		O.C.M.E.		June 22, 2007	
(5)		30. Name and add ass of person who completed cause of death (Item 23a)			
OeME		Mary G. Ripple MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, M	ID 21201		
	ate	31. Date filed (Month, Day Year) 32. Registrar's Signature			
Regis	rar	JUN GU CUUI Malana M. Docker			

DHMH 17 Rev 1/2001 OCME 2006

		For State Registrar		of Maryla	and / Depa		t of H	ealth ar	nd Me	ental Hyg	jiene eg. No.	)7	21955
Physic /Medi Exami	cal	1. Decedent's Name (First, Middle, ENEVA  4a. Facility Name (If not institution,	give street and nu					Location of	Death	2. Date of Dea Month	Day <b>20</b> 4c. County		3. Time of Death 3. 30 PM
Funeral Director		264-58-1148	E REHAB Sex 1□M 2□F	• & NU 7. Age (In y 64	RSING rs. last birthday) Yrs.	If Under Months		STVILL If Under 24 Hours		B. Date of Birth (Month, Day Sept I	Year)		CORGE 'S ace (State or Foreign try) 'H CAROLINA
vith the Maryland or 28a-f ehow	Director	10e. Street and Number	E GEORGE		CAPITO		Code			1	0g. Citizen of V	Vhat Coun	0d. Inside City Limits 1   Yes 2   No  try?
be filed within 72 hours after death with the Maryland ital Hygiene. Id other then "natural", or Iteme 23e or 28e-f ehow event, the Madical Examinar must be notified at	d by Funeral Director	11 PEPPERMILL  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Dec Armed Fo	rces? 2 ∐XNo ve		Was Deced			n? (Spec Puerto R	ify Yes or No- ican, etc.)		e - Amenca k, White, e	
of 2 should be filed within 72 hours att th and Mental Hygiene. 27 I emarked other then "natural" or rtraumetic event, the Madical Exert	e Completed	15. Decedent's (Specify only highest (Specify only highest (1 1 1 th)) 17. Father's Name (First, Middle, La	grade completed) College (	1-4or 5+)	life.	dent's Usua kind of woi DO NOT us USE W	rk done d se retired,	furing most o		7	16b. Kind of Bu  PRIV	ATE	ustry
s 1 and 2 should be f Health and Mental item 27 ie marked o other traumetic eve	To Be	JAMES RICHBUR 19a. Informant's Name/Relationship STEPHEN CLARK/	G (Type, Print)		19b. Mailir	ng Address	(Street a	nd Number o	GI or Rural	ADYS	YOUNG City or Town, EIGHTS,	State, Zip	Code) 20743
permit. Pages 1 and Department of Healtt important: if item 2?		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 4 □ Donation 5 □ Officer (Spee	☐Removal from		p. Place of Dispo cemetery, crer	sition (Nam	ne of ther place	9)	Da	te	20c. Location · BRENTWO	City or Tov	wn, State
permit. Departi importi		21. Signature Superal Service Line 23a. Part 1. Enter the disease, or co		-		7474	LAND		OAD	LANDOV	NKINS F ER,MARY		
icate be executed B physicien and burial-transit on its burial-transit on its part of the purial on its part of the purial on its part of the purial of the	dical Examiner	Saturntially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last	b	(or as a cons	equence of):								
that the death certificined by the attending pl	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 1 No 9 □ Unknown		irth 2 ☐ Fe antattime o	etal death 3	Ectopic pre					23d. Date Mon	of deliver	y Day Year
w requires that been signed b should be deta	Š	Part II. Other significant conditions  STROKE	contributing to de	eath but not r	esulting in the ur	nderlying ca	use give	n in Part I.					cause of death?
Physician: The law r this certificate has b and director, paga 2 s	Be Completed	25. Was case referred to medical						26. Place of	Death (	24a. Was ar autops perform 1 Yes 2	p ned? d A No 1	Vere autop rior to com eath?	sy findings available pletion of cause of
al or Attending Physicien: The law requires that the death certifics after death. I Director: Atter this certificate has been signed by the attending pt din by the funeral director, paga 2 should be detached for use as it	Certification: To	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 2 Accident 3 Suicide 6 Could not determine	28a. Date (Mont	of Injury h, Day Year)	28b. Time of Injury	M 28	A Other  Bc. Injury Work'	4 Mursir	ng Home	5 Reside			
Hoepital or 4 hours afte Funeral Dir ely filled in l	edical Certi	29a. Certifying F	Physician: To the aminer: On the ba	best of my k	nowledge death	occurred a	at the time	e, date and p	1200 200	City or Town	, State)		
To the within 2 To the complate	Me	29b. Signature and Hille of certifier		ioi otatog.			License	number 1520		29	d. Date signed $b-20$		* -
-(5)	10		AD, M.D.	17.	28 500	Print)	N	tve:	3 <i>E</i>	WASH	NGTON	D	= 10031
Sta , Registr		31. JUN 2 5 2007 (ar)	heren 32. A	b. B	reles								

		4	partment of Health and Me ertificate of Death	ntal Hygiene	
Physi		Decedent's Name (First, Middle, Last)     JOEL JOHN DEFALCO		Date of Death Month Day JULY 2,20	3. Time of Death 007 8:45P M
/Med Exam		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		County of Death
		9231 CRESENT LANE	LA PLATA		HARLES
Funera Directo		5. Social Security Number  219-11-2655  G. Sex  7. Age (In yrs. last birthday 35 Yrs. Usual Residence of Decedent	Months Days Hours Min.	Date of Birth (Month, Day, Year) AY 18,19	9. Birthplace (State or Foreign Country)  MD.
yland		10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits
Mar-	ctor	MD. CHARLES	LA PLATA		1 X Yes 2 □ No
ith th or 28	Director	10e. Street and Number	10f. Zip Code		zen of What Country?
sath v s 23e	rai	9231 CRESENT LANE	20646	U.S.	
Ind 21215-0036  be filed within 72 hours after death with the Maryland tal Hygiene. d other then "neturel", or items 23e or 28a-f show event, it a Madical Evantier mat be retified at	by Funeral	1 XNever Married 2 Married 1 Yes 2 X No	Was Decedent of Hispanic Origin? (Specifif Yes, specify Cuban, Mexican, Puerto Ric  1 ☐ Yes 2 No Specify:	y Yes or No- cen, etc.)	14. Race - American Indian, Black, White, etc. Specify: WHITE
5-0 72 hc	eted	(Specify only highest grade completed) (Giv.	edent's Usual Occupation  e kind of work done during most of working	16b. Ki	nd of Business/Industry
within me.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)	гиом	GOMERY WARD
N 2 5 5 7	ပိ	12 1 YR WAI	REHOUSEMAN  18. Mother's Name (F		EHOUSE Sumama)
	To Be	DAVID DeFALCO	VIOLA C		Jamane,
re, Naryland s 1 and 2 should be flie f Health and Mental Hy liem 27 ie marked oth other treumatic event	-		ing Address (Street and Number or Rural R	Route Number, City o	
			CRESENT LN. LA	PLATA, MI	20646
Baltimore,  bernit. Pages 1 ar  Department of Hea  Importent: If Item  any injury or other		I La bullar 2 (XICIemation 3 La Removal from State	ematory or other place)	200, 20	cation - City or Town, State
It Pa it. Pa rtmen rtent: njury		'4 Donation 5 Other (Specify) BRINSFIELD E	CHOLS CREMATORY 7	-5-07 CH	
Baltimor permit. Pages Department of I Importent: if ite any injury or or		1 21. 1/ (X)	2. Name and Address of Facility RAYMOND FUNERAL S LA PLATA, MD. 2064	ERVICE,	MD.
ate be executed  Wedica  Thysician and Thysician and The burial-transit		23a. Part 1. Enter the disease, or complications that baused the death. Do noter shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate that a first or that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	by suffixation		Interval Between Onset and Death
BOX 6  Bath certific attending p  for use as	hysician/Med		□Ectopic pregnancy □ Other (specify)	2	3d. Date of delivery Month Day Year
COTGS, F.C.  **requires that the di been signed by the should be detached	by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		se contribute to the cause of death?  ☐ No 3 ☐ Probably 4 ☐ Unknown
25 8 4	pieted			24a. Was an	24b. Were autopsy findings available
The The page	Compi			autopsy performed? 1 ☐ Yes 2 ☑ No	prior to completion of cause of death? 1 ☐ Yes 2 ☑ No
r VICAL FOR STATE OF	Be (	25. Was case referred to medical examiner?	26. Place of Death (C	Check only one)	
hys his	2	1€ Yes 2 No Hospital: 1 □ Inpatient 2 □ ER/Outpatie  27. Manner of Death 28a. Date of Injury 28b. Time of			
on on oding Phy th. After thi funeral	tion	1 □ Natural 5 □ Pending (Month, Day Year) Injury	Work?	Describe how injury	the head
DIVISION  To the Hospitel or Attending Pr within 24 hours after death. To the Funerel Director: After the compietely filled in by the funeral	ertification;	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)  Residure:	reet, factory, office 28f.	Location (Street and City or Town, State)	Number or Rural Route Number, 9231 CV Ca) ENT LN W10 2646
le Hospitu 124 hours e Funere letely fille	edical C	29a. Certifier (Check only one)  1 Certifying Physicien: To the best of my knowledge, deal 2 Medicel Examiner: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place, and	due to the cause(s)	and manner as stated
To th withir To th comp	Me	29b. Signature and title of certifier	29c. License number	29d. Date	signed (Month, Day, Year)
		yaria M. Tagam	D 005 508	83 7/	3/07
2		30. Nale and address of person who completed cause of death (Item 23a) (Type,	Print) pluta MD 2	0646	
	ate	30. Na e and address of person who completed cause of death (Item 23a) (Type, 1/6 5 5 wind 5 a p 32 Registrar's Signature 31. Date filed (Month, Day, Year) 32 Registrar's Signature			
Regis	rar	JUL 0 9 ZUUT JANGER AS APPL			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Day Dinkins Lucius 16, 2007 7:22 A. M June /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **Baltimore County** Northwest Hospital Center Randallstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1936 5. Social Security Number Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 70 247-58-5943 October 11, Director South Carolina Usual Residence of Decedent with the Maryland 10a. State 10c, City, Town or Location 10b. County 10d. Inside City Limits 28a-f show Examiner must be notified at Director **Baltimore** 1 XYes 2 □ No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 919 North Augusta Avenue 21229 United States death \ Funeral permit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature." any injury or other traumatic energy. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🗶 No Specify: Black Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Potomac Electric Elementary/Secondary (0-12) College (1-4or 5+) Power Company 6th grade Cable Installer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Dinkins Harvin Ethel Davis 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christina Davis Dinkins (Wife) 919 North Augusta Avenue; Baltimore, Maryland 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Baltimore County 1 XBurial 2 ☐ Cremation 3 □Removal from State June 22,2007Windsor Mill, Maryland King Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ly R. N. Horton Company Morticians, Inc. 600 Kennedy Street, N.W.; Washington, D.C. 20011 m 23a. Part1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Sepsis due to Bilateral Pneumonia /Medical Due to (or as a consequence of): Examiner Cerebrovascular Accident Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed Hypertension burial-tra Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 physician s the buria Physician/Medical Diabetes Mellitus; Acute Renal Failure attending ph IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached i 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy perforn 2**K** No Hospital or Attending Physician: 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2X No 1 X Inpatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 □Pending investigation 1 Natural Injury 2 Accident 1 ☐ Yes 2 ☐ No 24 hours after death Funeral Director: filled in by the 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 💢 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated the within To the YSICIAN 29c. License number 29b. Signature title of certifier 29d. Date signed (Month, Day, Year) June Sun who completed cause of death (Item 23a) (Type, Print) Northwest Hospital Center

ALLI M HARIS 5401 Old Court Road; Randallstown, Maryland 21133 VERA 32. Registrar's Sanatu State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Ernestine L. Frazier 2007 June /Medical 4b. City, Town, or Location of Death 4c. County of Death acility Name (If not inelitution, give street and number) Examiner WICEMICE ALISBURY REGIONAL MEDICAL LNINSULA If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days 1 ☐ M 2 🔀 F Dec 9, 89 ŃY 206-20-8065 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State 10b. County 28a-f shov 1 XYes 2 ☐ No ms 23a or 28a-f st must be notified **Funeral Director** MD Worcester Berlin 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 10214 Germantown Road 21811 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Black ò 3 ₩ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 7 is marked other than "natu traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Entreprenure 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ၉ Hobson Hudson Emma Henry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Trudell J. White/daughter 1925 E. Mayland St., Philadelphia, PA 19138 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of F important: If ite any injury or ot once. 1 Burial 2 □ Cremation 3 □ Removal from State 6/23/2007 St. Paul's Cemetery Berlin, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Emeral Service Licenses Lewis N. Watson Funeral Home 1618 West Rd., Salisbury, MD shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Cerebro Vascula Hemorrhogic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of): Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed nding physician and use as the burial-trar resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 Ø No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a 9∏Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ Srillad 2 No 3 Probably 4 Onknown Completed andidemia 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 No Vein 1∏ Yes 25. Was case referred to edical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA P 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 🖳 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

within 24 hours after death

To the Funeral Director:

206 - 20.5065

State Registrar 31. Date filed (Month, Day, Year)

Jeyed A.

29b. Signature and title of certifier

loo East Comoll

30. Name and address of person who completed cause of death (Item, 23a) (Type, Print)

32. Registrar's Signature

D0060715

54

Salisb

29d. Date signed (Month, Day, Year)

June 18 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 5:50 PM Edward lune 5 2007 George /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner NIA University of Maryland Medical Center Baltimore If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**X**M 2□ F Virginia 70 Director 219-34-5769 20,1937 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County In than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Frederick Brunswick 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or any fijury or other traumatic event, the Medical Examiner must be nonce. U.S.A. 14. Race - American Indian, 214 7th Avenue 21716 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐No Baltimore, Maryland 21215-0036 Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Animal Care Zoology 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Samuel William George <u>Mildred Stine</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 214 7th Avenue, Brunswick, MD 21716
of Disposition (Name of Date 20c. Location - City or Town, State Doris D. George - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place)

Lovettsville Union 20a. Method of Disposition June Marial 2 ☐ Cremation 3 ☐ Removal from State 2007 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 22. Name and Address of Facility Lovettsville, VA 21. Signature of Funeral Service Licenses Loudoun Funeral Chapels 158 Catoctin Circle SE, Leesburg, VA 20175 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or flear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Multisystem Organ

Due to (or as a consequence of): **Physician** disease or condition resulting in death) /Medical Examiner Neumopenic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner or Attending Physician: The law requires that the death certificate be executed Due to Kir as a consequence of): Lymphome and resulting in death) Last Physician/Medical 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) Division or Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No autopsy After this certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28h Time of 27. Manner of Death Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No neral Director: A 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours at To the Funeral Completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

DHMH 17 Rev 1/2001

Registrar

(Check only

Meena V

29b. Signature and title of certifie

Shah, MD

29c. License number

South Greene Street Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

June 15, 2007

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

22

2007

Direct permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at Baltimore, Maryland 21215-0036

Phys /Me Exar

Funer

Physicia /Medic Examine

To the Hospital or Attending Physician: The law requires that the death certificate be executer within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi

Division or Vital Records, P.O. Box 68760,

		1 - For State Registrar	State of Me	ar yrarra 7		tificate of				Reg. No.		21960	
Physici	an	Decedent's Name (First, Middle,						I 1	Date of De Month	Day	Year	3. Time of Death	
/Medic		Carolyn J.							une 2			9:55am™	
Examin	er	4a. Facility Name (If not institution,	-			4b. City, Town, Bowi	or Location of De	eath			County of Deat		
	Ž	13316 Mockings 5. Social Security Number		e (In yrs. last i	hirthday)	If Under 1 Yea		rs. 8 F	ate of Bir	th		hplace (State or Foreign	
uneral irector		214-30-0888 Usual Residence of Decedent	1 M 2 <b>X</b> F	72	Yrs.	Months Days		in. (/	Month, Da une 2	ay, Year)	l Co	verdale,MD	
It ow		10a. State 10b. County		10c. City, To	wn or Loc	ation						10d. Inside City Limits	
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23a c	alD	13316 Mockingb	oird Lane			2072	0			US	5A		
ems er m	Funeral	11. Marital Status	12. Was Decedent   Armed Forces?	Ever in U.S.	13. W	as Decedent of Yes, specify Cu	Hispanic Origin? ban, Mexican, Pu	(Specify erto Rica	Yes or No n, etc.)	)-	<ol> <li>Race - Ame Black, Whit</li> </ol>		
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 □ Never Married 2 □ Marrie 3   Widowed 4 □ Divorced	ed 1 ☐ Yes 2 🗷 N If Yes, Give Year or Dates:	10	1	□Yes 2 <b>∏</b> No	Specify:				Specify: Wh		
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arked or atic eve	To Be	William R. Bar					Betti		ummir				
27 is mar r trauma		19a. Informant's Name/Relationsh Melanie Saderho		3	_		et and Number or gbird La					Zip Code)	
If Item or othe		20a. Method of Disposition  1  Burial 2  Cremation	3 ☐Removal from State			ition (Name of atory or other p		ine 2			ington,		
rtant	1	4 □ Donation 5 □ Other (Sp 21. Signature   f Fun-ral Service L	-	Metro		tan Cre		200				V 2 1	
any i		21. Signature il Puri dai Service L	Cerisee		6	512 NW	ress of Facility Crain Hw	Beal y Bo	I Fur wie P	neral MD 20	1 Home 0715		
		23a. Part1. Enter the disease, or a shock, or heart failure. List of	complications that caused only one cause on each lin	the death. D	o not ente	r the mode of d	ying, such as card	diac or res	spiratory a	rrest,		Approximate Interval Between Onset and Death	
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D 68	1 400	IE EEMALE.											
To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use	Physician/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 MNo 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal dea		Ectopic pregnar Other <i>(specify)</i>	ncy				23d. Date of de Month	livery Day Year	
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5)		30. Name and address of person of RAKESH A COR	1	eath (Item 23:	a) (Type, F	Print) ANE T	BOWIE,	mp	20	715			
Sta		31. Date filed (Month, Day, Year) JUN 2 5 2007	32. Registr	ar's Signa	W					-			
Regist	al	JUN & D COO!	Little VI										

			1 - For State Registrar	State of Mary	•	rtificate of I			Reg. No.		21951
F	Physici	an	1. Decedent's Name (First, Middle, La		-			2. Date of De Month	ath Day	Year	3. Time of Death
1	/Medic	cal	LINDA	ERIS	(	GILES		JUNE	21 2007		8:30 A M
1	Examir	ier	4a. Facility Name (If not institution, giv 13107 BAR GEESI				r Location of Death MARLBORO			y of Death CE GEC	RGE'S
, ,	Funeral Director		217 00 7754	7. Age (In ) ☐ M 2☐ F 53	vrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birl (Month, Da JUNE 2	y, Year)	9. Birthp Coun	
	land ow		Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or Lo	cation				1	0d. Inside City Limits
	a-f sh	ctor	MD PRINCE	GEORGE"S	UPPI	ER MARLBO	RO				1√Yes 2□No
	or 28	<b>Funeral Director</b>	10e. Street and Number	GOUDE		10f. Zip Code			10g. Citizen of		ntry?
	eath v ns 23a must	eral	13107 BAR GEESE  11. Marital Status	12. Was Decedent Ever i	nUS 13	20774	isnanic Origin? (Sne	cify Yes or No		ce - Americ	an Indian
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any	by Fun	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		If Yes, specify Cuba 1 ☐ Yes 2 ☐ No	ispanic Origin? (Spe an, Mexican, Puerto I Specify:	Rican, etc.)	Bla	fy: BLA	etc.
15-0	n 72 h "natu edical	letec	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	16a. Dece	dent's Usual Occup kind of work done o	ation during most of workir f)	g	16b. Kind of E	Business/Ind	dustry
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Baltimore,	es 1 a of Hea fitem rothe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cemation 3 ☐	20 Removal from State	b. Place of Dispo cemetery, crei	sition (Name of matory or other place	ce) D	ate	20c. Location	- City or To	own, State
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68760,	tificate be executed ig physician and as the burial-transit	fedical		d							
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.O. Box	w requires that the death cer been signed by the attendin should be detached for use	Physician/	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time 9 ☐ Unknown	etal death 3	Ectopic pregnancy Other <i>(specify)</i>				ate of delive onth	ery Day Year
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or Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		ot 3 DOA Othe	26. Place of Death		1		
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ion	Attending I r death. ector: After by the funer	atio	1 XNatural 5 Pending 2 Accident investigation		r) Injury		Work?			jary decemen	
Division	or Atter frer de Directe in by ti	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28f. Location (Street and Number or Rural Route Number, City or Town, State)			al Route Number,				
Ц	To the Hospital or Attene within 24 hours after death To the Funeral Director: completely filled in by the	Medical Ce	29a. Certifier 1 Ži Certifying Ph (Check only one) 2 ☐ Medical Exar	nysician: To the best of my niner: On the basis of exan and manner stated.	knowledge, deat nination and/or in	h occurred at the tir vestigation, in my o	me, date and place, a pinion, death occurre	and due to the ed at the time,	cause(s) and n date and place	nanner as si , and due to	tated. the cause(s)
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)		1	1 Kynn a	· Duomas,	mos	200	057400		June	21.	2007
1/	1/2	1	30. Name and address of person who			*	NE LIBOR	A.C.A.T.T.T.	V		-
A.	Sta	te	LYNN ANETTE T  31. Date filed (Month, Day, Year)	HOMAS M.D. 12	gnature	ANTILE LA	INE LARGO,	MARYLA	AND 207	/4	
	Registr		JUN 2 5 2007	han D.	book						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 10f per FH/wichd/6-25-07/dls Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2007 Physician JUNE ANGELENE ELIZABETH HOWARD 22, 7:50 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner RUXTON HEALTH OF DENTON CAROLINE DENTON 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2**X** F 212-03-2004 89 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at DELAWARE SUSSEX SEAFORD Director 1X Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 213 NORTH BRADFORD STREET -10073 19973 AMERICA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ Specify: WHITE 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry within 72 Elementary/Secondary (0-12) College (1-4or 5+) LEGAL SECRETARY LAW 12 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; If item 27 is marked oth-17. Father's Name (First, Middle, Last) Be JULIUS WRIGHT WHEATLEY NELLIE BOWMAN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOYCE SPRATT NIECE P.O. BOX 891 HURLOCK, MARYLAND 21643 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 MCpemation 3 Removal from State CREMATORY OF DELMARVA 6/23/07 DELMAR, DELAWARE 4 ☐ Donation 21. Signature ral Service Lice WATSUNG YATES FUNERAL HOME, INC. FRONT & KING STREETS SEAFORD, DELAWARE caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. Approximate 73 Part1. Enter the disease shock, or heart failure or complications that list only one cause of Immediate Cause (Final disease or condition resulting in death) Physician عاطءطن /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (15 and 15 Due to (or as a consequence of): Examine be executed burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes certificate 2 □ No 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Suursing Home 5 Residence 6 Other (Specify) 2 100 1 🔲 Yes ျှ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death pletely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral D Decritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) an 00053255

31. Date filed (Month, Day, Year) State JUN 2 5 2007 Registrar

Melinde

Lednum Are Proston MD 21655 ے دی 32. Registrar's Signature

136

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

			1- State of Maryland / State of Maryland / State		rtment of Healt tificate of Dea			giene Reg. No.	2.1963
			Decedent's Name (First, Middle, Last)				2. Date of Dea	ath	3. Time of Death
	Physici /Medi		Olga Hamay				Month July	Day Year 02, 2007	12:40 A.M.
	Examir		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Locat	tion of Death		4c. County of Deat	
			St. Vincent Care Center		Emmitsbu	rg		Frederi	ck
	Funeral Director		5. Social Security Number  579-66-7523  6. Sex 1 □ M 2 ☑ F  7. Age (In yrs. last bite) 89	irthday)_ Yrs.	If Under 1 Year If Un Months Days Hou	nder 24 Hrs. urs Min.	8. Date of Birt (Month, Day Nov. 20	y, Year) 9. Birt Co , 1917 Penn	hplace (State or Foreign untry) ISYlvania
	pur *		Usual Residence of Decedent           10a. State         10b. County         10c. City, Tow	wn or Loo	ation				
	sho	ក							10d. Inside City Limits 1 Yes 2 □ No
	the N	ect	MD Frederick Emmit	tsbu:				40 - 077	
	with	ă			10f. Zip Code			10g. Citizen of What Co	untry?
	leath	era	335 South Seton Avenue  11. Marital Status 12. Was Decedent Ever in U.S.	13 W	21727 /as Decedent of Hispanic	c Origin? (Sne	offy Vee or No-	U.S.A.	rican Indian
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other then "naturel", or Itams 23a or 28a-f show any injury or other treumatic event, "to Medical Evandres must be notified at once.	by Funeral Director	Armed Forces?  1 Never Married 2 Married  1 Yes 2 No  If Yes, Give  Year or Dates:	lf	Yes, specify Cuban, Mex  ☐ Yes 2 No Specify Cuban	xican, Puerto F	Rican, etc.)	Black, White	e, etc.
21215-0036	2 hou	pe	15. Decedent's Education 16a	a. Decede	ent's Usual Occupation			16b. Kind of Business/	nite
75	hin 7: on "n	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give k life. D	ind of work done during i O NOT use retired)	most of workir	ng	Religious (	
7	ed wit	Com	College 5+	Nur	sing			Daughters of	-
g	al Hy al Hy d oth	Be (	17. Father's Name (First, Middle, Last)		0	lother's Name	(First, Middle,	Maiden Sumame)	
<u>ya</u>	Ment Ment arke	10	Daniel Hamay			Julia	Chyza		
Maryland	2 shand and is m			b. Mailing	Address (Street and Nu	ımber or Rura.	l Route Numbe	r, City or Town, State, Z	ip Code)
	1 and Health em 27 ther to				South Seton		e, Emmi		21727
altimore,	ages nt of t: If it		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	ery, crema	atory or other place)	!	a10	20c. Location - City or	lown, State
틀	it. P. rtme rtani		4 □ Donation 5 □ Other (Specify) ST. JC  21. Signatur of Funeral Service Licenser 2		H'S P.H. Name and Address of Fa	7/6/2	2007	EMMITSBURG.	MD.
m	Department of the partment of		John M Stoler			SI		UNERAL HOME	
			23a. Party. Enter the disease, or complications that caused the death. Do	not enter	210 W. MAII	N ST., h as cardiac or	EMMITS r respiratory an	BURG, MD, 2	1727 Approximate
k	Pnysician		Immediate Cause (Final	1	lle. +x	-1	,		Interval Between Onset and Death
	/Medical		dise or condition resulting in death)  a	of):	down I	aum	~		1 mer
	Examiner		attornal	tic	Cardina	لايممي	$a - \Delta$	11801/	20 400
Ĺ	D =	ner	Sequentially ist conditions, if any, leading to immediate cause. Enter Underlying	of):		() P () CO			1/0
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8760,	ficate be executed physician and sthe burial-transit	Ě	Due to (ods b) consequence	of):					0
87	cate t	edical	d						
ox e	it the death certific by the attending p tached for use as		IF FEMALE: 23b. Was decedent prognant 23c. If yes, outcome of pregnancy						
8 B	atten for u	cian	in the past 12 months?		Ectopic pregnancy Other (specify)			23d. Date of deli- Month	very Day Year
o.	the d by the	Physician/M	1 ☐ Yes 2 ☑ No 9 ☐ Unknown 9 ☐ Unknown		5 (Speeny)				
	The law requires that the death certifute has been signed by the attending to age 2 should be detached for use a	by PI	Part II. Other significant conditions contributing to death but not resulting in	in the und	derlying cause given in Pa	art I.	23e. Did to	bacco use contribute to	the cause of death?
ğ	w require been sig should b		Monic Rend trul	fic	ency		1 □ Y	es 2⊡No 3□Pro	bably 4 Unknown
ecords,	aw re	plet	V	V			24a. Was a		opsy findings available
Y	hysicien: The law nis certificate has I director, page 2 s	Completed					autops perform	med? death?	ompletion of cause of
Vital	sien: artifica ctor.	ВеС	25. Was case referred to medical examiner?		26. PI	lace of Death	Check on or	2-1	20,10
01	Physic this ce al dire	10	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Ou	utpatient	3□ DOA Other: 4反	Nursing Hom	ne 5 🗆 Reside	ence 6 Other (Spec	ify)
	ding Ph th. : After th funeral	on:		Time of Injury	28c. Injury at Work?	21	8d. Describe h	ow injury occurred	
<u> </u>	Attendi death. ctor: A y the fu	cati	2 Accident investigation		M 1 ☐ Yes 2	2 □No			
DIVISION	or Atter of Direction by	Certification:	4 Homicide determined 28e. Place of Injury - At home, fa	arm, stree	et, factory, office	2	8f. Location (Si City or Town	treet and Number or Rui n, State)	ral Route Number,
_	pours sours  source		29a. Certifier 1 ☑ Certifying Physician: To the best of my knowledge	a dooth s	non-man at the time, date	a and alass as			
	To the Hospitel or Attending Physicien: within 24 hours after death.  To the Funerel Director: After this certific completely filled in by the funeral director.	Medical	29a. Certifier  1 Certifying Physician: To the best of my knowledge (Check only one)  2 Medical Exeminer: On the basis of examination an and martner stated.	nd/or inve	stigation, in my opinion, o	death occurre	d at the time, d	ause(s) and manner as ate and place, and due	stated. to the cause(s)
	To th Within To th compl	Me	29b. Signature and title of certifie	1.0	29c. License numb	oer	2	9d. Date signed (Month	, Day, Year)
			Illa Squall	M	1/18	2701		JULY 2, 2	007
			30. Name and address of person who completed cause of death (Item 23a) (	(Type, Pr	rint)	7		0011 2, 2	<i></i>
	\		ALAN CARROLL, M.D., 310 S. SETON	AVE.	EMMITSBUR	RG, MD.	21727		
	Sta Registr	_	31. Date filed (Month, Day, Year) 32 degistrar's Signature	1	A 29 B				
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Physician 8:00 PM Violet Marie Harris 2007 DOUG 10 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington Washington County Hospital Hagerstown 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 🛛 F Director 216-22-7664 April 21,1927 MD 80 Usual Residence of Decedent r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No MD Washington Hancock 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? death with an "natural", or Items 23a or Medical Examiner must be 118 Fulton Street 21750 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. filed within 72 hours after 1 Tes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Specify: <u>ک</u> 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Mr Elementary/Secondary (0-12) College (1-4or 5+) t of Health and Mental Hygiene.
If Item 27 is marked other than or other traumatic event, the M 8 Seamstress <u>Clothing Manufacture</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be pe Pages 1 and 2 should then on the Page 1 and Men William R. Keefer 2 Mary Elizabeth Mills 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Robert E. Harris/Son 10707 Connor Dr. Williamsport, MD 21795 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page Department o Important: If any Injury or once. 1 ∑Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 06/29/07 Jerusalem Christian Warfordsburg, PA 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 141 West Main Street Grove Funeral Home, P.A. Hancock, MD 21750-0368 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List or more cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** DAYS /Medical Due to (or as a consequence of): Examiner CHOLECYSTITIS Sequentially list conditions, if any, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-trar Due to (or as a consequence of) Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed certificate 1□ Yes 2☑No Division or Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 1 ☑ Natural 28d. Describe how injury occurred 28c. Injury at Work? After t 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00061410 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SYED EAST ANTIETAM ST. HAGERSTOWN CHAFFAR A. MID 251 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of Ma		Jepartmei <i>Certifica</i>			Mentai Hy	/gien Reg. N			
	Physici	20 20	1. Decedent's Name (First, Middle, La	st)					2. Date of D Month	eath		3. Time	of Death
	/Medic		SOONKI KIM JUN						JUNE	21,	2007 Year	9:2	27A M
	Examir	er	4a. Facility Name (If not institution, give		COLLDE			Location of Dea		4c. County of Death			
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	or death with the Marylar tems 23a or 28a-f show at invel be notified at	rai	17120 QUEEN VI			100		0877			sa		
ING 21215-0036  be filed within 72 hours after death with the Maryland tal Hygiene. d other than "naturel", or items 23e or 28e-f show event, the Medical Exercition meast be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent If Armed Forces? 1 Yes 2 14 If Yes, Give Year or Dates:		13. Was Dece If Yes, spe		spanic Origin? ( n, Mexican, Pue Specify:	Specify Yes or Norto Rican, etc.)	0-	14. Race - Amer Black, White Specify: A			
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Baltimore,	Pages 1 an nent of Heal int: If Item 2 iry or other		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif.	Removal from State		Disposition (Na y, crematory or GE WAS)			Date /24/07		Location · City or T		
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i	. **		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between								ate etween		
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=	eath. or: After the fune	cation	1 Natural 5 Pending 2 Accident investigation		Year) In	jury M	28c. Injury at Work?  M 1 Yes 2 No			how inju	injury occurred		
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	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral or the funeral o	Medical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of liner: On the basis of and manner stat	examination and	death occurred Vor investigation	at the time i, in my opir	, date and plac nion, death occ	e, and due to the urred at the time,	cause(s date an	s) and manner as s d place, and due to	stated. o the cause(	s)
	vithi To t	Σ	29b. Signature and title of certifier			290	c. License r	number		29d. Da	ate signed (Month,	Day, Year)	
			) All	-22		I	00021	1033		JU	INE 22,	2007	
-	2)			300 GEORG	IA AVE	ENUE SI	LVEF	R SPRI	NG MD	209	06		
	Stat Registra	_	31. Date filed (Month, Day, Year) JUN 2 5 2007	32. Registra	's Signature	D							El i
	A 54 Di Di	- 4	3011 70	Marie	./								

DHMH 17 Rev 1/2001

iciar		= State Registrar			Certifica	te of Death			eg. No.	7 1	3. Time of Death	
	_	Decedent's Name (First, Middle, La	_					Date of Dea Month	Day	Year		
dica	1 -	Betty J.  4a. Facility Name (If not institution, given	Law		4h Cih	, Town, or Location of		June	21 20 4c. County	007	11:05 P	
nine	r j	Homewood at Crum				ederick	J. D. D. L.			deri	r k	
al		5. Social Security Number 6.	Sex 7. Ag	e (In yrs. last birti	hday) If Unde	er 1 Year   If Under		Date of Birth (Month, Day			lace (State or Forei	
or		192-20-2101	1□M 213tF	82	rs. Months	Days Hours	Min.	pril 2	9,1925	9,1925 Pennsylvania		
	-	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location					1	Od. Inside City Limi	
	.		1			1_					1 ☐ Yes 2 🔀 I	
	9 -	Maryland Frederick Frederick  106. Street and Number 107. Zip Code							log. Citizen of W	/hat Cou	ntry?	
Č	5	7401 Willow Road	#112			21702			Unit	ed S	tates	
	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S.	13. Was Dec	edent of Hispanic Ori ecify Cuban, Mexican	igin? (Specif	y Yes or No-		- Ameri	can Indian,	
,	2	1 Never Married 2 Married	Armed Forces?		1 ☐ Yes			an, etc.)	Specify	k, White, . Ն	mite Thite	
	۵	3 ☐ Widowed 4 ☒ Divorced	If Yes, Give Year or Dates:									
3	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a.	Decedent's Us (Give kind of w	ual Occupation rork done during mos use retired)	t of working		16b. Kind of Bu	siness/In	dustry	
	Ē	Elementary/Secondary (0-12)	College (1-4or	5+)	Rate				Ins	uran	ce	
3	ပိ	17. Father's Name (First, Middle, Las	t)		nace		er's Name (F	First, Middle,	Maiden Sumam			
0	o O	Ross S. Dalton				Ev	elvn	Wetz1e	r			
		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number,							State, Zip	Code)		
once.		John Law / Son				th Drive	Wa1ke	rsvill	e, Mary	1and	21793	
	-1	20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 [	Demoval from State	20b. Place of cemeter	Disposition (Na y, crematory or	ame of other place)	June 2		20c. Location -	City or To	own, State	
		4 Donation 5 Other (Spec			er Crem	natory	20	07			Maryland	
once		21. Signature of Funeral Service Lice	ense <i>e</i>			and Address of Facili						
a	1	23a. Part1. Enter the disease, or cor shock, or heart failure. List only	Lato	11		possumtow				Mary	Approximate	
er	Examiner											
		that initiated events		a consequence o	of):							
	cai	that inflated events resulting in death) Last		a consequence of	of):		- William					
	cai	that initiated events	Due to (or as	of pregnancy 2 ☐ Fetal death	of): 3 ⊟Ectopic 5 ⊡ Other (		- 300		23d. Dat Mor		ery Day Year	
	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 XNo	Due to (or as  d.  23c. If yes, outcome  1 Live birth  4 Pregnant a  9 Unknown	e of pregnancy 2  ☐ Fetal death t time of death	3⊟Ectopic 5	specify)	ı.		Mor	ribute to t	Day Year	
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	edical Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2  No 9  Unknown  Part II. Other significant conditions  25. Was case referred to medical examiner? 1  Yes 2  No 27. Manner of Death 1  Natural 5  Pending investigating inv	Due to (or as  d.  23c. If yes, outcome 1	e of pregnancy 2 Fetal death t time of death  but not resulting in  ent 2 EP/Ou  uny 28b. T  iury - At home, faitc. (Specify)	3 Ectopic 5 Other (: the underlying  tpatient 3 I I ime of njury M rm, street, factor door investigation	26. Place 26. Place 27. Other: 4 1 1 28c. Injury at Work? 1 Yes 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	e of Death (ursing Home 28)	24a. Was a autop performed of the control of the co	Model of the state	ribute to 1 3 Pro Were autorior to octeath? Pyes er (Special ed anner as and due 1 d (Month,	Day Year the cause of death? bably 4 dnkno oppy findings availa ompletion of cause 2 No fy) al Route Number, stated, o the cause(s)	
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DOD 6/01/07

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Social Security Number 7. Age (In yrs. last birthday, **Funeral** 1 M 2 □ F Yrs. Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State 10b. County 10c. City, Town or Location 0d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No ANNEARUNDEL Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? UNITMORE 2106 . S.A 12. Was Decedent Ever in U.S. Armed Forces? 1 Meyes 2 □ No If Yes, Give Year or Dates: 1456-57 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cupan, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Maryland 21215-0036 2⊠No 1 Tyes þ 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Be ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MITTER SMYRNA, DE Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 4 Donation 5 Other (Specify)

21. Signature Fund of Service (icense) ARTENT CREMATORY -7-07 22. Name and Address of Facility Daugherty Family Funeral Home And Cremation Center, P.A. 2601 Mountain Road - Pasadena, MD, 21122 Part I. Enter the disease of shock, or heart failure. Li Approximate Interval Between Onset and Death complications that cause only one cause on each l Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) hysician /Medical sequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and as a consequence of) Division or Vital Records, P.O. Box 68760 the attending physician Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only on 1 Yes No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Watural 2 Accident Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No after death Director: 3 ☐ Suicide 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) m 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2. Registras Signature Burne mo 30 31. Date filed (Month, Day, Year) Dawe

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 1057 SUNE 21 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a 🕰 cility Name (If not institution, give street and number) Examiner KEGIONAL MEDICAL CENTER SALISBURY

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Wiczmico ENINSULA Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months -48-946 1 M 2□ F MARY MnD Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 28a-f show be notified at 1 ☐ Yes 2 No 10 Director 1Com100 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö 8 Koad items 23a d Examiner must Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 N Yes 2 □ No If Yes, Give Year or Dates: 65 - 68 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Saltimore, Maryland 21215-0036 "natural", or þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) the Medical (Give kind of work done during most of working life. DO NOT use retired) Mountaire than Elementary/Secondary (0-12) College (1-4or 5+) s 1 and 2 should be filed w of Health and Mental Hygier iteπ 27 Is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 7. Father's Name (First, Middle, Last) Be arshall ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2
Department of Health a
Important: If item 27 Is
any injury or other trai Marshall (wite) STINE 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition f Burial 2 ☐ Cremation 3 ☐ Removal from State #1 Mt. Wesley Cem # 2 L 5 Other (Specify) 5+ 21. Signature of Funeral Service Licensee WISabella Bennie Smith md 21801 SALLSburry FUNEROL Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ISCHEMIC CARDIOMYOPATHY **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CORONARY ARTERY DISE ASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed SEVERE LEFT VENTRICULAR DYSFUNCTION burial-trar Division or Vital Records, P.O. Box 68760, physician Completed by Physician/Medical VENTRICULAR TACHYCARDIA/FIBRILLATION the as attending IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 | Fetal death ned by the attent detached for u Year Month in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown DEPENDANT DIABETES MELLITIS 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an CHRONIC RENAL s certificate has t lirector, page 2 s autopsy performe 2 No 1∐ Yes HEART CONGESTIVE To the Hospital or Attending Physician: 26. Place of Death (Check only one) director, Be 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1₽Yes 2□ No ို this 28a. Date of Injury (Month, Day Year) within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Injury 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 010

State Registrar

DHMH 17 Rev 1/2001

**ORIGINAL** 

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dala

IMD

32. Registrar's Signature

rakash

31. Date filed (Month, Day, Year)

06

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Dalisbry, no 21801

614 Earlern More Drive

onauncey Morris, S	1- For State Certificate of De	ath	eg. No.
Physician/	Registrar  1. Decedent's Name (First, Middle,Last)	2. Date of Deat	h 3: Time of Death
Medical Examiner	Chauncey Morris Sr.  4a. Facility Name (if not institution, give street and number)  4b. C	Month June 21, 2	007 0645 hrs
		ewark ·	Worcester
Funeral	l		h(MM/DD/YYYY) 9. Birthplace (State or Foreign
Director	215-62-1811 1 M 2 F 53 Yrs.	onths Days Hours Min. July	19, 1953 Country) VA.
au À	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
show show of need.	VA. Accomack Gargar	-tha	1 Yes 2 No
the Maryland a or 28a-f she tified at once Director		·	Og. Citizen of What Country?
ith the 23a or notific	27468 Second Street  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was De	23414 cedent of Hispanic Origin? ( Specify Yes or No-	U. S. A.  14. Race - American Indian, Black,
r death with , or items 23.		pecify Cuban, Mexican, Puerto Rican, etc.)	White, etc.
after call, or inter m	3 Widowed 4 Divorced If Yes, Give Year 1 Yes	2 No specify:	specify: Black
5-0036 ed within 72 hours after dygiene. other than "natural" the Medical Examine Completed by		sual Occupation (Give kind of work done f working life. DO NOT use retired)	16b. Kind of Business/Industry
036 ithin 75 ne. r than tedical		k Driver	Perdue Transportation Maiden Surname)
filed w Hygie d othe show	17. Father's Name (First, Middle, Last)		Maiden Surname)
21215-0036 ould be filed within 7 d Mental Hygiene. s marked other than ite event, she Medica To Be Comple	Henry Morris  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Add	Filen Reid  Iress (Street and Number or Rural Route Num	aber, City or Town, State, Zip Code)
	Chauncey Morris Jr. 135 A	CKert Ave. Salisbu. (Name of cemetery, Date	ry, N.C. 28144
Baltimore, MD bernit. Pages I and 2 sho Department of Health and Important: If item 27 is injury or other traumati	1   Burial 2   Cremation 3   Removal from State   crematory or other p	lace)	
Baltimo permit. Page Department Important: injury or oth	4 Donation 5 Other Specify: Holy Unity	emetery June 29,2007	Treherneville, Virginia Morris
Balt permit. Departi Import injury	21. Signature, Lumerat S. 12. Name	Box 175 Nassawado	Morris
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the m failure. List only one cause on each line.	ode of dying, such as cardiac or respiratory arre	est, shock, or heart Approximate Interval Between Onset and
/Medical Examiner	Immediate Cause (Final disease a, Multiple Injuries	3	Death
	b but to (or as a consequence oi).		
iner	Sequentially list conditions, lif any, leading to immediate Due to (or as a consequence of):		
Insit  Examiner	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):		
xecute n and l-trans	dunpended		
60, ate be execu hysician and the burial - tra	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery
687 certifice dding p	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal decedent pregnant in the past 12 months?		Month Day Year
b. Box 687 the death certific oy the attending ched for use as the	1 Yes 2 No 9 Unknown g Unknown	(Specify)	
P.O. I that the med by the detache	Part II. Other significant conditions contributing to death but not resulting in the under	, , , , , , , , , , , , , , , , , , , ,	bacco use contribute to the cause of death?
ls, P quires t en sign uld be c		1Yes	an 124b. Were autopsy findings available
Records, The law requires ficate has been sig	· · · · · · · · · · · · · · · · · · ·	autop perfor	sy prior to completion of cause of med? death?
I Re- n: The tificate or, pag	25. Was case referred to medical	1 ✓ Yes 26.Place of Death (Check only one)	2 No 1 Yes 2 No
Vital sysicians this certification of Beel	examiner? 1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3	- loubon	Residence 6 Other: Scene
n of Jing Ph After t funeral	27. Manner of Death  1 Natural 5 Pending Jun 21, 2007 Unit 1, 2007 Uni	28c. Injury at Work?  1 Ves 2 No 28d. Describe to 28d. De	now injury occurred le collision
ision Attenor or death ector: by the	2 Accident Investigation 28e. Place of Injury - At home, farm, street, fa	- Improper	Street and Number or Rural Route Number, City
Division o Division o Hospital or Attending 24 hours after death. Funeral Director: After stely filled in by the funeral of Control	Suicide 6 Could not be determined (Specify) Major Road / Highway	or Town, S	
Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be deached for use as the burial - transit Medical Certification: To Be Completed by Physician/Medical Ex	29a. Certifier (Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, and manner stated.		
M S H S H	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	unesc	O.C.M.E.	June 22, 2007
5		et, Baltimore, MD 21201	
State Registrar	31. Date filed (Month, Day, Year) 32. Figistrar's Signature		
DHMH 17 Rev 1/2001	ORIGINAL		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** McAllister Barbara 24 2007 4:00 June /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Glade Valley Nursing Center Frederick <u>Walkersville</u> 8. Date of Birth (Month, Day, Year) June 14,1941 If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 146-32-8281 66 Director New Jersey Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Man Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f sh any injury or other traumatic event, the Medical Examiner must be notified it Frederick Walkersville Director 1XYes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 135 Edinburgh 21793 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Realtor Real Estate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pressler Chester Ann Keller ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 135 Edinburgh Way / Walkersville, Maryland 21793 John D. McAllister / husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Resthaven Mem.Gardens 06/29/2007 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stauffer Funeral Home 21. Signature of Funeral Service Licensee 40 Fulton Ave. / Walkersville, MD 21793 23a. Part 1. Epter the disease, or complications that caused the death. Do not enter shock or heart failure. List only one cause on each inc. Approximate Interval Between Onset and Death the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) **Physician** PYCARS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner that the death certificate be executed burial-transit and resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown certificate has been si rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1∐ Yes 2 No 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 1 Yes 2 No ဥ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: or Attending 1. Natural Injury 5 Pending investigation 1 Yes 2 No 2 ☐ Accident Director: / 3 ☐ Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours an To the Funeral D filled Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only

State Registrar

29b. Signature and title of certifier

Baltimore, Maryland 21215-0036

Box 68760.

P.O.

Division or Vital Records,

of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month. Dav. Year)

FREAERICK

3

State Registrar

ORIGINAL

Georgia Ansait 3-41 Silver pring MD 20902

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROINTAN FARAH FAR

31: Date filed (Month, Day, Year)

M.0

9801

32. Registrar's Signature

. #	3	1 - State Registrar  1. Decedent's Name (First, Middle, Last		dr	So E	tiricate oi	Deati	7	2. Date of De		1	3. Time of	Death -
Physici		Michael Marra	,						Month June	Day 20	Year 200		
/Medio		4a. Fecility Name (If not institution, give	street and number)			4b. City, Town,	or Location	of Death	June		County of Dea		<i>,</i> ,
		705 Americana Dri	ve Apt 4	6		Annapo1	is			A	nne Ar	undel	
Funeral		Social Security Number     6. Se	3M 00E	e (In yrs.	last birthday)	If Under 1 Yea Months Days		r 24 Hrs. Min.	8. Date of Bir (Month, Da	rth ay, Year)	9. Bi	rthplace (State of	r Foreign
Director	9		X <sup>M 2   51</sup>		Yrs.				Oct. 1			w Ýork	
and w		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation						10d. Inside Cit	y Limits
Maryl f sho	ō	Maryland Anne Ar	undo1		Annaı	01ia						1 🗆 Yes	2∏No
72 hours after death with the Maryland natural', or iteme 23a or 28e-f show dical Examiner must be notified at	Director	10e. Street and Number	unuer	1	Aimaj	10f. Zip Code				10g. Citiz	en of What C		ΛΛ
3a oi	Ö	705 Americana Dri	ve Apt 4	6		21	403			Unite	ed Sta	tes	
deau	Funerai	11. Marital Status	12. Was Decedent Armed Forces? 1 \( \text{Yes} \)		.S. 13.	Was Decedent of f Yes, specify Cu		rigin? (Sp	ecity Yes or No			erican Indian,	
a de		1 ☐ Never Married 2 ☐ Married	1 □ Yes 217 If Yes, Give	No		1 □ Yes XXX No			Tricari, dic.)		Specify: W		
LEX.	d by	3 ☐ Widowed 4 XXX ivorced	Year or Dates:										
"nat adica	Completed	15. Decedent's Edi (Specify only highest grad	ucation de completed)		16a. Deced	dent's Usual Occi kind of work don DO NOT use retir	upation e during mo	st of work	ing	16b. Kin	d of Busines	s/Industry	
is marked other then sumatic event, the Market	μ̈́	Elementary/Secondary (0-12)	College (1-4or	5+)		are Arc					Compu	toro	
other ent, I		17. Father's Name (First, Middle, Last)			DOLL	are Arc.	_		e (First, Middle	, Maiden S		LEIS	
Ked ic ev	To Be	David Marra					Mar	ie Fa	nelli				
liem 27 is marked other then "natural", or items 23s or 28e-f show other traumatic event, the Medical Examiner must be notified at	-	19a. Informant's Name/Relationship (T)	ype, Print)		19b. Mailir	ng Address (Stree				er, City or	Town, State,	Zip Code)	
important: if item 27 is any injury or other training once.		Christine Summa /	Sister		14-41	. 140 St:	reet	Whit	estone,	New	York	11357	
item othe		20a. Method of Disposition			Place of Dispo	sition (Name of natory or other pl	ace)		Date	20c. Loc	ation - City o	r Town, State	
ant: if		1 ☐ Burial	Hemoval from State	Ft.		ln Crema		6/21	/2007	Brent	twood,	Marylan	ıd
mporte any inju		21. Signature of Funeral Service Licens	600									ral Home	
E = 8		Michel ( ) Ilm	_		14	7 Duke	of G1	ouces	ter St.	. Anna	apolis	, MD 214	.01
		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that cause ne cause on each li	d the deati ne.	h. Do not ent	er the mode of dy	ring, such a	s cardiac	or respiratory a	irrest,		Approximate Interval Bety	ween
sician		Immediate Cause (Final disease or condition	$\sim$ $\sim$	rall	cell	lina	Ca	nce				Onset and D	leath .
edical iminer		resulting in death)	Due to (or as	a conseq	uence of):.	J		·				1	
7	_	Sequentially list conditions,	b										
isit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a conseq	uence or):								
al-tray	Examine	that initiated events resulting in death) Last	c Due to (or as	a conseq	uence of):								
sicien and burial-transit		l l											
physi	edic		o										
attending ph d for use as th	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			1e				23	3d. Date of de	alivery	
e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant a			Ectopic pregnan Other (specify)	су				Month	Day Y	'ear
ed by the a detached f	hys	9 🗆 Unknown	9□ Unknown										
70.00	by	Part II. Other significant conditions co	ntributing to death b	ut not res	ulting in the u	nderlying cause g	iven in Pari	1.	1			to the cause of de	
been sig	b								15	Yes 2	]No 3□F	Probably 4 □U	nknown
SC	Completed								24a. Was		24b. Were a	utopsy findings a	available
oa o	Con								perfe 1 ☐ Yes	ormed?	death? 1 ☐ Ye		
this certificete al director, pag	Be	25. Was case referred to medical examiner?						ce of Deat	h (Check only	one)			
this cral dire	2	1 ☐ Yes 2 No	Hospital: 1   Inpatio		ER/Outpatien	1 3LI DOA		lursing Ho	me <b>X</b> Res			ecify)	
fter	-uo	27. Manner of Death 1 ØNatural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year)	28b. Time of Injury	W			28d. Describe	how injury	occurred		
: <u>0</u>	Certification;	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	290 Place of In	une At he	mo form etc		Yes 2		ORE Location	(Straat and	Alumbarar	Rural Route Numi	
Direc in by	ertif	4 Homicide determined	28e. Place of In building, el	c. (Specif	y)	eet, ractory, office	•			wn, State)	Number or F	turai Houte Numi	)er,
pellii liiled		29a. Certifying Phy	sician: To the best	of my kno	wledge death	occurred at the	time date s	and place	and due to the	C31100/0/0	and manner:	ac stated	
e Fur	edical	(Check only 2 Madical Exami	ner: On the basis of and manner st	t examina	tion and/or in	estigation, in my	opinion, de	ath occur	red at the time,	date and p	place, and du	e to the cause(s)	1
To the Funeral Directo completely filled in by the	Me	29b. Signature and title of certifier				29c. Licer	nse number			29d. Date	signed (Mor	oth, Day, Year)	
	00	Jeanne	ven			D	528	30		JUV	ne 20	1200	7
200	W	30. Name and address of person who co	ompleted cause of o	leath (Iten	1 23a) (Type,	Print)						, -	:
to	1	Jeanine wern	er,900	Ba	tgat	e (loco	1#30	20	Anno	polo	SN	1200 T	101
	_	31. Date filed (Month, Day, Year)			ture					W			

DHMH 17 Rev 1/2001

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

after death.

I Director: A in by the fu filled

or Attending Physician: within 24 hours a

To the Funeral I completely the

Medical State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

6 Could not be determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Uma Prasad, M.D., 2100W Pennsylvania Ave., NW, Washington, DC 20037 32. Registrar's Sign

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

17310 (p.c.)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

June 22, 2007

Montgomery General Hospital    Social Security Number   Social Security	3. Time of Death 2007  3. Time of Death 5:30p M  Country of Death  Montgomery  9. Birthplace (State or Foreign Country) Maryland  10d. Inside City Limits 1  Yes 2 No  zen of What Country?  sited States  14. Race - American Indian, Black, White, etc.  Specify: White and of Business/Industry
Aux   Facility Name (If not institution, give street and number)   Aux   Facility Name (If not institution, give street and number)   Aux   Facility Name (If not institution, give street and number)   Aux   Aux   Facility Name (If not institution, give street and number)   Aux   Aux   Facility Name (If not institution, give street and number)   Aux   Facility Name (If not institution, give street and number)   Aux   Facility Name (If not institution, give street and number)   Aux   Facility Name (If not institution, give street and number)   Aux   Facility Name (If not institution, give street and number)   Aux   Facility Name (If not institution, give street and number)   Aux   Facility Name (If not institution, give street and number)   Aux   Facility Name (If not institution, give street and number)   Aux   Facility Name (If not institution, give street and number)   Aux   Facility Name (If not institution, give street and number)   Aux   Facility Name (If not institution, give street and number)   Aux   Facility Name (If not institution, give street and number)   Aux   Facility Name (If not institution, give street and number)   Aux   Facility Name (If not institution, give street and number)   Aux   Facility Name (If not institution, give street and number)   Aux   Facility Name (If not institution, give street and number)   Aux   Facility Name (If not institution, give street and number)   Aux   Facility Name (If not institution, give street and number)   Aux   Facility Name (If not institution, give street and number)   Aux   Facility Name (If not institution, give street and number)   Aux   Facility Name (If not institution, give street and number)   Aux   Facility Name (If not institution, give street and number)   Aux   Facility Name (If not institution, give street and number)   Aux   Facility Name (If not institution, give street and number)   Aux   Facility Name (If not institution, give street and number)   Aux   Facility Name (If not institution, give street and number)   Aux   Facility Name (I	Specify: White
Montgomery General Hospital  Social Security Number  Olney  Social Security Number  5. Social Security Number  5. Social Security Number  6. Sex  1□ M 2対 F  7. Age (In yrs. last birthday) Months Days Hours Min.  Months Days Hours Min.  Jan. 30, 193	Montgomery  9. Birthplace (State or Foreign Country)  Maryland  10d. Inside City Limits  1 □ Yes 2 ☑ No  zen of What Country?  sited States  14. Race - American Indian, Black, White, etc.  Specify: White
Funeral Director  5. Social Security Number  6. Sex 1 Months Days Hours Min.  7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.  7. Age (In yrs. last birthday) And Days Hours Min.  7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.  9. Date of Birth (Month, Day, Year) Jan. 30, 193	Maryland  10d. Inside City Limits 1 □ Yes 2 ▼ No  zen of What Country?  itted States  14. Race - American Indian, Black, White, etc.  Specify: White
	1 □ Yes 2 ☑ No zen of What Country? ited States  14. Race - American Indian, Black, White, etc.  Specify: White
Maryland Montgomery Damascus    Maryland Montgomery Damascus   106. Zip Code   109. Citiz   109.	zen of What Country?  ited States  14. Race - American Indian, Black, White, etc.  Specify: White
William Hartley    Maryland   Montgomery   Damascus   10f. Zip Code   10g. Citiz   10e. Street and Number   20872   Un   20872   Un	ited States  14. Race - American Indian, Black, White, etc.  Specify: White
20872 Un  20945 Ridge Road  12. Was Decedent Ever in U.S. Armed Forces? 1   Never Married 2   Married Forces? 1   Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 1   Never Married 2   Married Forces? 1   Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) 12. Was Decedent Ever in U.S. Armed Forces? 1   Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 1   Yes 2   No   If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1   Yes 2   No   If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1   Yes 2   No   Specify: 1   Yes 2   No   If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1   Yes 2   No   If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1   Yes 2   No   If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1   Yes 2   No   If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1   Yes 2   No   If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1   Yes 2   No   If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1   Yes 2   No   If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1   Yes 2   No   If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1   Yes 2   No   If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1   Yes 2   No   If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1   Yes 2   No   If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1   Yes 2   No   If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1   Yes 2   No   If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1   Yes 2   No   If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1   Yes 2   No   If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1   Yes 2   No   If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1   Yes 2   No   If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1   Yes 2   No   If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1   Yes 2   No   If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1   Yes 2   No   If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1   Yes 2   No   If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1   Yes 2	14. Race - American Indian, Black, White, etc. Specify: White
1. Marital Status   12. Was Decedent Ever in U.S.   13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)   1   1. Marital Status   1   1   1. Marital Status   1   1	Black, White, etc.  Specify: White
Secondary (0-12)   Top   Secondary (0-12)	Specify: White
15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  16b. King (Give kind of work done during most of working life. DO NOT use retired)  17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden State)  William Hartley  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Administrator  18. Mother's Name (First, Middle, Maiden State)  William Hartley  Freda Unknown	nd of Business/Industry
The state of the s	
The state of the s	nercial Banking
The state of the s	
Takin   William Haltley	
19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or	r Town, State, Zip Code)
المَّا الْهُ الْمُ الْهُ الْمُلْمُ الْمُ الْمُعْلِمُ الْمُعِلَّالِمُ الْمُعْلِمُ الْمُعْلِمُ الْمُعْلِمِلْمُ الْمُعِلِّمُ الْمُعِلِّمُ الْمُعِلِّمُ الْمُعِلِّمِ الْمُلْمِ الْمُعِلِّمِ الْمُعِلِّمِ الْمُعِلِّمِ الْمُعِلِّمِ الْمُعِلِمِ الْمُعِلِّمِ الْمُعِلِّمِ الْمُعِلِمِ الْمُعِلِمِ الْمُعِلِمِ الْمُعِلِمِ الْمُعِلِمِ الْمُعِلِمِ الْمُعِلِمِ الْمُعِلِمِ الْمُعِلِمِ الْمُعِلِمِ الْمُعِلِمِ الْمُعِلِمِ الْمُعِلِمِ الْمُعِلِمِ الْمُعِلِمِ الْمُعِلِمِ الْمِعِلِمِ الْمِعِلِمِ الْمِعِلِمِلْمِ الْمِعِلِمِ الْمِعِلِمِ الْمِعِلِمِ الْمِعِلِمِ الْمِعِلِم	MD 21770
20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Loc	cation - City or Town, State
1   Second of Disposition   1   Burial 2   Cremation 3   Removal from State   Cemetery, Crematory or other place)   Pine Grove Cemetery June 27,2007   Mt.	Airy, Maryland
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Lck Maryland 21702
23a. Part1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate Interval Between
Physician Immediate Cause (Final disease or condition a Ollawian Cara Cer	Onset and Death
/Medical resulting in death)  Due to (or as a consequence of):	
Examiner  Sequentially list conditions, b. ———————————————————————————————————	
Sequentially list conditions, if any, leading to immediate the conditions of any, leading to immediate Cause (Disease or injury)  Due to (or as a consequence of):	
per per per per per per per per per per	
Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last	
1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 gronths?	23d. Date of delivery Month Day Year
	use contribute to the cause of death?  No 3 Probably 4 Unknown
Q in gr Q E autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1   Yes 2   No   No   No   No   No   No   No	1 ☐ Yes 2 ☐ No
25. Was case referred to medical examiner?  1	6 ☐Other (Specify)
27. Magner of Death 1 Natural 28a. Date of Injury 1 Natural 28b. Time of Injury 28b. Time of Injury 28c. Injury at Work? 3 Suicide 3 Suicide 4 Describe how injury 28c. Injury at Work? 4 Natural 28c. Injury at Work? 4 Natural 28d. Describe how injury 4 Natural 4	ry occurred
27. Manner of Death   28d. Date of Injury	nd Number or Rural Route Number, 3)
29a. Certifier 29a. Certifier (Check only (Check only and due to the cause(s) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place and due to the cause(s)	
one) and manner stated.  29b. Signature and title of certifier  29d. Dat	te signed (Month, Day, Year)
1/2 Mem 10046312 06	12362
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  VINCENT OLICITE (MS) MEH OCNEY MS  State Registrar  31. Date filed (Month, Day, Yaar)  25 2007	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** PORTILLO 03 12 AM FELIX UNE 2007 21 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE UNIVERSITY OF MARYLAND MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. .Sex 1M 2□F 8. Date of Birth (Month, Day, May 8, 5. Social Security Number Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months Hours Country) Salvador 1971 E1 none Director 36 Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Maryland Baltimore 1X Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 611 South Decker Avenue 21224 El Salvador Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. I and 2 should be filed within 72 hours after of teath and Mental Hygiene. Fin 27 is marked other than "natural", or Itel 1 X Never Married 2 ☐ Married Specify: White Baltimore, Maryland 21215-0036 1X Yes 2 No Specify: Salvadoran <u>Ş</u> 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6th Dish Washer Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Valeriano Garcia Portillo Maria Ercilia Portillo de Garcia 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health em 27 Nelson Portillo Garcia/brother Baltimore, Maryland, 21224 permit. Pages 1 and Department of Health Important: if item 27 any Injury or other 1 once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State San Miguel, El Salvador Family Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 07-01-07 22. Name and Address of Facility W.H. Bacon Funeral Home, 21. Signature of Funeral Service Licensee Inc. CC361 3447 14th Street, N.W. Washington, D.C. 20010 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician BURKITT'S LYMPHOMA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. if yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy signed by the atte in the past 12 months? Month Year Day 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 【 No 24a. Was an page 2 autopsy perform 1□ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 70 this To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death 28a. Date of Injury 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: i or Attending Fafter death. (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) CLUNE 21 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 S. GLEENE ST GRAHAM SNYDER BAUTIMORE, MD 21201 31. Date filed (Month, Day, Ye 32. Registrar's Signal Se State

DHMH 17 Rev 1/2001

Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav Year Month **Physician** 6:50 AM Daniel Ryan July 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner University of Maryland Medical Center Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 M 2 □ F 56 Director 212-54-7448 7-22-1950 DC Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 28a-f show ral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 No Hedgesville Director WV Morgan 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 80 Yellow Poplar Ln. 25427 USA mit. Pages 1 and 2 should be filed within 72 hours after death anaturent of Health and Mental Hygiene. octant: If Item 27 Is marked other than "natural", or Items 23at Injury or other traumatic event, the Medical Examiner must Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 💽 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2X No Specify: White Specify ò 3 Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Moving/Storage Co. Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Mark Ryan Martha Rose 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health a Important: If Item 27 Is any Injury or other tran Allison Ryan/Wife 80 Yellow Poplar Ln., Hedgesville WV 25427 Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Omps Crematory 7-02-2007 Winchester, VA 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service I 22. Name and Address of Facility Rosedale Funeral Home 917 Cemetery Rd., Martinsburg, WV 25404 Approximate Interval Between Onset and Death 23a. art | Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immeriate Cause (Final discase or condition resulting in death) Sepsis days Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐ Pregnant at time of death 9☐ Unknown 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1 MInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Matural

Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and stelly filled in by the funeral director, page 2 should be detached for use as the burial-transit Division or Vital Records, P.O. Box 68760, within 24 hours a To the Funeral C

Baltimore, Maryland 21215-0036

Certification: To 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 14.D P19840 July 1, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 South Greene Street Baltimore MD 21201 Connie Tena M.D Year) 2. Registrar's Signature 31. Date filed (Month, Day, State

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Registrar DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

22650 Cedar Lane Court, Leonardtown, MD 20650 Avani D. Shah, M.D., 32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

47066

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** 1:00 P Robert Russev /Medical June 20, 2007 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 9309 Woodberry Street Seabrook Prince George's 5. Social Security Number If Under 1 Year | If Under 24 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1**⊠** M 2□ F 315-22-0573 Director 80 Sept 1, 1926 Indiana Usual Residence of Decedent 10c. City. Town or Location 10a State 10h. County 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at Yes 2 No Director Maryland Prince George's Seabrook 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? within 72 hours after death with 9309 Woodberry Street 20706 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1∑Yes 2 □ No WWII If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: à Specify: 3 ☐ Widowed 4 ☐ Divorced "natural", White Completed traumatic event, the M. dl. al 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 4+ is marked other than Flementary/Secondary (0-12) Aeronautical engineer Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be fi and Mental H permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Fred H. Russey Clara Heffernan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Kathleen G. Russey 9309 Woodberry Street, Seabrook MD 20706 (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a, Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Chesapeake Crematory | 6/22/2007 | Beltsville, MD 21. Signature of Funeral Service Licensel 22. Name and Address of FacilityRendon-Hale Funeral Home 9013 Annapolis Road, Lanham MD 20706 tassicia 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Lung cancer /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and the burial-transit the death certificate be executed Due to (or as a consequence of): P.O. Box 68760 Physician/Medical as attending IF FEMALE: asn If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy for in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No After this certificate has autopsy performed' 1 Yes 2 No Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 XNo Other: 4 ☐ Nursing Home 5 🖾 Residence 6 ☐ Other (Specify) c 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Natural Injury 5 Pending investigation M 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) in by t 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 🔀 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 ■ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ■ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

31. Date filed (Month) Registrar DHMH 17 Rev 1/2001

REVA.S. GILL

6510 Kenilworth 32 Registrar's Signature

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		- negistiai	rtificate of Death		J. No.	
Physicia	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
/Medic		KYUNG WON SEO	the Oile Town and and in at Double	JUNE	4c. County of Dea	
Examin	er	4a. Facility Name (If not institution, give street and number)  ST. AGNES HOSPITAL	4b. City, Town, or Location of Death BALT I MORE		+c. County of Dea	
		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Bji	thplace (State or Foreign
Funeral Director		604 06 5358 1 N 2 F 37 Yrs.	Months Days Hours Min.	(Month, Day, Y) FEB, 26		S. KOREA
		Usual Residence of Decedent				
how	_	10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits 1 ☑ Yes 2 ☐ No
Ba-f s	Director	CA LOS ANO				
or 2	Dire	10e. Street and Number	10f. Zip Code	100	g. Citizen of What C	,
s 23a nust	ra	525 S. BERENDO ST #203	90020	ecify Vec ex No	S. KOR	
ital Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	y Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 □ No If Yes, Give Λ  Year or Dates:	Was Decedent of Hispanic Origin? (Spif Yes, specity Cuban, Mexican, Puerto	Rican, etc.)	Black, Whi	te, etc.
"natural	Completed by	15 Decedent's Education 16a Dec	edent's Usual Occupation e kind of work done during most of work DO NOT use retired)	king 16	 6b. Kind of Business	
nd Mental Hygiene. marked other than matic event, the M	ᇍ	Elementary/Secondary (0-12) College (1-4or 5+)	PRIETOR		DDTII	
Hygi other ent, th	ပ္	17. Father's Name (First, Middle, Last)		e (First, Middle, Ma	PRIVATE aiden Surname)	
e d d	To Be	WON SUK SEO	SOON	DON CH	IOI	
mar mar mat	-		ing Address (Street and Number or Ru			Zip Code)
Ith a		HO JOO LEE /WIFE 525	S. BERENDO ST	# 203 I	LOS ANGE	LES CA 90
t of Heal		20a. Method of Disposition 20b. Place of Disposition	oosition (Name of ematory or other place)	Date 20	Oc. Location - City o	r Town, State
nent of int: If its iny or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Hemoval from State	· · · · · · · · · · · · · · · · · · ·	26/07 A	LEXANDR	TA. VA
Department Important: I any injury o		LIZINOI O	22. Name and Address of Facility CH	ARLES HI	NDS FUN	ERAL SERV
o a m o			2303 KAYAK DR.			
*7		23a. Part1. Enter the disease, accomplications that caused the death. Do not e shock, or heart failure. List only one cause on each line.				Approximate Interval Between
nysician		Immediate Cause (Final disease or condition  BRAINSTEM HE	MORICHAGE			Onset and Death
Medical		resulting in death)  Due to (or as a consequence of):				
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	ner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying				
nd transi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):				
ian a	<u>~</u>	resulting in death) Last Due to (or as a consequence of):				
ng physician and as the burial-transit	edical	d				
ding p		IF FEMALE: 23c. If yes, outcome pf pregnancy			004 P-464	
e attending id for use a	Physician/M	in the past 12 months?  In the past 12 months?  In the past 12 months?  In the past 12 months?  In the past 12 months?  In the past 12 months?  In the past 12 months?	□Ectopic pregnancy □ Other (specify)		23d. Date of de Month	Day Year
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been signed by the should be detached	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.			to the cause of death? robably 4 □Unknowr
2 88	Completed			24a. Was an autopsy perform	ed? prior to	
certificate rector, pag		25. Was case referred to medical	26 Place of Dog	th (Check only one)	-	s 2 No
is certificate h	o Be	examiner?  1   Yes   2   No	Other:		nce 6 □Other (Sp	ecify)
erah di		27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at	28d. Describe how		
th. r: After th e funeral	ţi	1 ☑ Natural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation	Work?  M 1 ☐ Yes 2 ☐ No			
after death.  Director: After this certification by the funeral director, I	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, so building, etc. (Specify)	street, factory, office	28f. Location (Stre City or Town,		Rural Route Number,
within 24 hours after death  To the Funeral Director: completely filled in by the	Medical Co	29a. Certifier (Check only one)  1 CertifyIng Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.				
within 24 <b>To the F</b> complete	Mec	29b. Signature and title of certifier	29c. License number	29	d. Date signed (Mor	nth, Day, Year)
≥ ⊨ ŏ		main Camela M. Posale, MD	P18614		UNE 19.	
	i .					
E		30. Name and address of person who completed cause of death (Item 23a) (Type	e. Print)			
6		30. Name and address of person who completed cause of death (Item 23a) (Type MAICIA ICOSAULS 900 S CATON AVE	ALTIMORE, MD 212	29		

SEO, KYUNGWON

			For State Registrar	State of Marylan		rtificate of		, ,	eg. No.	
	Physicia		Decedent's Name (First, Middle, Last     DEBORAH V.	STEELE				2. Date of Deat Month JUNE		ear 9:55A M
	/Medic		4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, o	r Location of Death	30111	4c. County of	Death
			4740 KING JOHNS			UPPER 1	MARLBORO  If Under 24 Hrs.	0.0.1(8:4)		GEORGE'S
ı.	Funeral Director		298-48-3932	ex 7. Age (In yrs. 56	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, JAN 9 1	Year)	D. Birthplace (State or Foreign Country) DHIO
	land ow		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
	e Mary a-f sh iffied	ctor	MD PRINCE	GEORGE'S	UPPER	MARLBORO				14 Yes 2 No
	or 28	Funeral Director	10e. Street and Number	7 11437		10f. Zip Code		11	0g. Citizen of Wh	•
	eath w	eral	4740 KING JOHNS	12. Was Decedent Ever in U	S 13.3	207		ecify Yes or No-	U.S.	A. American Indian,
0000	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at one)	by Fun	11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		If Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto Specify:	Rican, etc.)		White, etc. BLACK
5	72 hoi natura lical E	eted	15. Decedent's Ed (Specify only highest gra	ducation de completed)	16a. Dece	dent's Usual Occup	oation during most of worki d)	ing	16b. Kind of Busi	ness/Industry
7	within ane.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)					GOVERNI	frator
7	filed v Hygie other 1	Be Co	17. Father's Name (First, Middle, Last,	2+	1 1 N V	ESTIGATO	18. Mother's Name	(First, Middle, M		IENI
/land	Mental Mental arked aric ev	To B	CHESTER STEELE				RUTI	HIE	MAE	WILLIAMS
, Mar	and 2 sho alth and 127 Is ma er trauma		19a. Informant's Name/Relationship ( RONALD STEELE/SO				and Number or Rura NS WAY UP			
o e	ges 1 a t of He If item or oth		20a. Method of Disposition 1 ABurial 2 □ Cremation 3 □			sition (Name of matory or other place	ce)		20c. Location - C	
Dallimo	it. Pac		4 Donation 5 Other Repect			CEMETERS  2. Name and Addre				,MARYLAND
מ	Depa Impo		21. Signature of Futurary envice Life	1566			OVER ROAD			NERAL HOME ND 20785
			22a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the deat one cause on each line.						Approximate Interval Between
O	Physician		Immediate Cause (Final disease or condition resulting in death)	a. <u>CARDIOVAS</u>	CULAR					Onset and Death
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×	entifica ding ph	_	IF FEMALE:	23c. If yes, outcome pf pregna	anov				1	
O. DOX	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live birth 2 Feta 4 Pregnant at time of d	al death 3 [	Ectopic pregnanc Other (specify)	у		23d. Date Mont	
, T	s that ined by	by Ph	Part II. Other significant conditions	contributing to death but not res	ulting in the u	nderlying cause giv	ven in Part I.	23e. Did tot	oacco use contrib	ute to the cause of death?
cords	equire sen sig ould b							1 □ Ye	es 2□No 3	Probably 4 Unknown
ž Š	e law r has be	Completed						24a. Was a	n 24b. We	ere autopsy findings available or to completion of cause of ath?
<u></u>	n: Th ficate or, pag		25. Was case referred to medical				00 Plans of Doort		24 No 1	Yes 2 No
5	ysicia is certi directo	To Be	examiner?  1 1 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatier	nt 3 DOA Oth	26. Place of Death ner: 4 ☐ Nursing Ho		ence 6 □Other	(Specify)
5 =	ng Ph fter th		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of injury (Month, Day Year)	28b. Time o Injury	Wor	ry at		ow injury occurred	
VISION	ttendi death. stor: A	icati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not b		ome farm str		Yes 2□No	28f Location /St	treet and Number	or Rural Route Number,
2	al or A s after il Dire	Certification:	4 ☐ Homicide determined	building, etc. (Specif	fy)	,,,		City or Town	n, State)	or riard ribato realizad,
	ne Hospita 24 hours ne Funera aletely fille	Medical C	29a, Certifier 1 ☑ Certifying Pr (Check only one) 2 ☐ Medical Exam	nysician: To the best of my kno niner: On the basis of examina and manner stated.	owledge, deat ation and/or in	h occurred at the ti	me, date and place, opinion, death occur	and due to the c red at the time, d	ause(s) and mani late and place, ar	ner as stated. d due to the cause(s)
		Me	29b. Signature and title of certifier	)		29a Licens		2	9d. Date signed	(Month, Day, Year)
	S		1/6	<b>V</b>	00.) =		38183		8/10	1101
	0)		30. Name and address of person who NADU TUAKLI M.D.				COLUMBIA.	MARYLAN	D 21044	
45	Sta		31. Profiles (Mynn) Pan Year)	32. Registrar's Si						

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Month Barbara Aleese Smith 19 2007 10:10P June /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Clinton Nursing Home Clinton

If Under 1 Year | If Under 24 Hrs. Prince George's 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🗓 F Director 597-30-9738 80 31. 1926 Wash. DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location ss 1 and 2 should be filed within 72 hours after death with the Marylan of Heath and Mental Hygiene of the 23a or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show cother traumatic event, the Medical Examiner must be notifiled at 1 X Yes 2 □ No Director Maryland Prince George's Clinton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 9211 Stuart Lane 20735 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Housewife Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Douglas Grisby Alma (Unknown) ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) #3B, Laurel, MD 20723 Livingston Rood Fort WASHington, many laws.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State o	f Marylar			nt of Health ar te of Death	nd Mer	ntal Hygie		
	Physici	o m	1. Decedent's Name (First, Middle,	Last)					2.	Date of Death Month	Day Ye	3. Time of Death
	/Medic		MELVYN		SMIT	H				JUNE	21 200	7 2:47 P M
	Examir	er	4a. Facility Name (If not institution, WASHINGTON	_		ΤΔΤ.		, Town, or Location of 'AKOMA PARK			4c. County of C	
6	Funeral			6. Sex	7. Age (In yrs.		If Unde	r 1 Year   Il Under 24	4 Hrs.   8.	Date of Birth	Q	Birthplace (State or Foreign
· Orl	Director		579-74-4851	1 📉 M 2 🗆 F	51	Yrs.	Months	Days Hours	Min. FE	(Month, Day, Ye EB. 1 19	956 W	ASHINGTON, DC
	and		Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ity, Town or Lo	cation					10d. Inside City Limits
	Mary -feh	tor	DC			WASHI	NGTO	N				1 ☐ Yes 2 ☐ No
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	ath wi	rai	700 BONINI ROA					0032			U.S.A.	
21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. and Mental Hygiene and Mental Hygiene. I enterled other than "natural; or theme 23a or 28a-f ehow aumatic event, the Macical Examiner must be natified at	by Funeral I	11. Marital Status  1 ♣Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	Armed Fo	2 (Ž)LNo ve		Was Dece f Yes, spe l □ Yes	dent of Hispanic Origin offy Cuban, Mexican, I 2 <sup>1</sup> No Specify:	in? (Specify Puerto Rica	Yes or No- an, etc.)		American Indian, Vhite, etc. BLACK
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121	within ne.	Completed	Elementary/Secondary (0-12)	College (	1-4or 5+)			ork done during most of see retired)	or working		TO TO T T T A A	m re
0 0	filed v Hygie other t		12th 17. Father's Name (First, Middle, L	ast)			COUNS		's Name (F)	irst, Middle, Mai	PRIVA	TE
/lan	should be and Mental marked o	To Be	MELVYN SMITH							BARRETT		
Ξ	s 1 and 2 should f Health and Mer item 27 ie marke other traumetic		19a. Informant's Name/Relationsh CLARICE M. YOU		HER			S (Street and Number OOD BLVD U				
Ĕ			20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation	3 □Removal from	State	Place of Dispo cemetery, cren	natory or i	other place)	Date		c. Location - City	or Town, State
Ë	t. Pages rtment of I rtant: If its njury or o		4 ☐ Donation 5 ☐ Other (Sp	ecify)	R			EMATORY 6/		007 RI	VERDALE	,MARYLAND
Ba	permit. Page Department of Important: If any Injury or once		21. Sign Tree of Funeral Strvice L	nsee	-			nd Address of Facility	٠ ف			ERAL HOME
4.6			25a. Part1. Enter the disease, or o shock, or heart failure. List o	complications that of	aused the dea			${\color{red}{ m LANDOVER}}$ ${\color{red}{ m R}}$ de of dying, such as ca				ND 20785 Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		PTIC SH							Onset and Death
A	/Medical Examiner		resulting in death)	-	(or as a consec							
R		e	Sequentially list conditions		GESTIV		FAI	LURE				
	uted d ansit	Examin	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		EMIA	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,						
oʻ	e exectan an arrial-tr	Exa	resulting in death) Last		(or as a consec	quence of):						
8760	cate be executed physician and the burial-transit	dicai	•	d. PEI	RIPHERA	L VASCU	ILAR	DISEASE				
O. Box 6	at the death certifi by the attending I tached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown		ointh 2 ☐ Feta nant at time of c	aldeath 3□	Ectopic p				23d. Date of Month	delivery Day Year
ت. ت	s that t ned by e deta	by Ph	Part II. Other significant condition	s contributing to d	eath but not res	sulting in the ur	derlying o	cause given in Part I.		23a. Did tobac	co use contribute	e to the cause of death?
Hecords,	The law requires that tte has been signed b page 2 should be deta	ed b	END STAGE RE	NAL DISEA	ASE				_	1 🗌 Yes	2 □\No 3 □	Probably 4 Unknown
ဝင္	law re as be	Completed								24a. Was an autopsy	24b. Were	autopsy findings available to completion of cause of
		Con								performer 1 ☐ Yes 2 ☐	d? death	1? 📆
Vital	sician: The law certificate has l irector, page 2 s	o Be	25. Was case referred to medical examiner?	Hospital: 154		15010		Other		heck only one		
0	g Phys er this eral di	$\vdash$	1 ☐ Yes 2 ☒ No 27. Manner of Death	28a. Date	of Injury	ER/Outpatien 28b. Time of		DA 4 Nursi 28c. Injury at Work?		5 Residence Describe how i	e 6 Other (S	Specify)
0	tending Fleath. tor: After the funer	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investiga	ition	th, Day Year)	Injury	М	Work? 1 ☐ Yes 2 ☐ No	0			
DIVISION	Hospital or Attending Physician: 44 hours alter death. Funeral Director: After this certific tely filled in by the funeral director.	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ed 289. Place	ol Injury - At h ng, etc. (Speci	ome, larm, stre	eet, factor	y, office	28f.	Location (Stree City or Town, S	t and Number or State)	r Rural Route Number,
:	To the Hospital or Attervision within 24 hours after de To the Funeral Direct completely filled in by the	edicai (	29a. Certifier 1 ☐ Certifying (Check only one)	xaminer: On the b	best of my kno asis of examina ner stated.	owledge, death ation and/or inv	occurred	at the time, date and j	place, and occurred a	due to the caus it the time, date	e(s) and manner and place, and o	r as stated. due to the cause(s)
1	To the within 2 To the complet	29b. Signature and III of certifier 29c. License number 29d. Date signed (Month, Day, Year)							onth, Day, Year)			
Λ						ms	2/	10630	5+		6/2	2/0+
/	(2)		30. Name and address of person w	.D. 7610	CARROL	L AVE		TAKOMA PA	RK, M	ARYLAND	20912	
	Sta Registr	-	31. Date filed (Month, Day, Year)	32. R	egistrar's Signa	feel						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend, item 2 per doc 887-8-1-07 yt.
State of Maryland Department of Health and Mental Hygiene.

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2007. **Physician** Day GERTRUDE SMITH 21 2006 JUNE 10:30& /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death HEARTLAND NURSING HOME ADELPHT 8. Date of Birth (Month, Day, Year)
9 1921 PRINCE GEORGE'S If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 217-14-7907 1 M 2 XF Country) MARYLAND Director 85 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show are, injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director MD PRINCE GEORGE'S UPPER MARLBORO 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 20774 U.S.A. 11318 KETTERING PLACE Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 BLACK 1 ☐ Yes 2 🗓 No Specify. ģ Specify. 3 Widowed 4 □ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10th GOVERNMENT NURSE ASSISTANT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) WALTER SNOWDEN WILLIAMS JANTE ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LINDA CRAIG/NIECE 11318 KETTERING PLACE UPPER MARLBORO, MARYLAND 20774 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) RIVERDALE CREMATORY 6/28/2007 RIVERDALE, MARYLAND Signature of Functial Servi 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME Licensee 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MULTIPLE BRAIN TUMORS /Medical Due to (or as a consequence of): Examiner SEPSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed END STAGE RENAL DISEASE Due to (or as a consequence of): Box 68760. Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? death? 1 ☐ Yes certificate 2 💟 No 1∐ Yes 2**X** No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 🖾 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) Hospital: 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 24 Natural 5 Pending investigation Injury 1 TYes 2 TNo 2 Accident after death Director: filled in by the 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) D17874 22, 2007 JUNE 30. Name and address of person who completed called of death (Item 23a) (Type, Print) SANKARAN MAYAR M.D. 3717 38th AVENUE COTTAGE CITY, MARYLAND 20772 32. Registrar's Sign stire 31. Date filed (Month, Pay 7) JUN 2 5 2007 State Registrar

		1 - For State Registrar	State of Maryla		artment of rtificate of			Re	g. No.	41955
Physici	an	Decedent's Name (First, Middle, L.						Date of Death Month	Day Year	3. Time of Death
/Medic			Ida Pauline To	11iver				ine 3	30 2007	0320 A <sup>M</sup>
Examir	ner	4a. Facility Name (If not institution, gi			4b. City, Town		of Death		4c. County of Death	
		Laurelwood Care 5. Social Security Number 6.		s. last birthday	E1kto		24 Hrs. 8	Date of Birth	Cecil 9 Bigh	place (State or Foreign
Funeral Director			1□M 2\F 80	Yrs.	Months Day		Min.	Month, Day, ine 30,	Year) Cou	cucky
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show say figury or other traumatic event, the McGoal Examinar must be millied at ance.		10a. State 10b. County	10c. C	City, Town or L	ocation					10d. Inside City Limits
Mar B-1-8	햦	Maryland Cecil		E1kton						1 X Yes 2 ☐ No
th the	Funeral Directo	10e. Street and Number			10f. Zip Code			10	g. Citizen of What Cou	ntry?
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er de	une	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of If Yes, specify Cu	f Hispanic Ori Iban, Mexicai	igin? (Specify n, Puerto Rica	Yes or No- an, etc.)	14. Race - Ameri Black, White,	
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Mental Hy Mental Hy arked oth	10	Christopher Jos	nes			Ha	ala Mea	ade		
d 2 sho th and 1 7 is mu traums		19a. Informant's Name/Relationship	(Type, Print)	19b. Mail	ing Address (Stre	et and Numb	er o <i>r R</i> ural Ro	oute Number,	City or Town, State, Zi	o Code)
and and n 27		David Mallery/S				Road,			elaware 197	
P T Ite		20a. Method of Disposition 1   ☐ Buriaf 2 ☐ Cremation 3		cemetery, cre	osition (Name of matory or other p	lace)	July 5	$5,$ $ ^2$	Oc. Location - City or T	own, State
mit. Pages partment of portent: If it portent: If it y injury or o		4 ☐Donation 5 ☐ Other (Spec	ify) Mei	morial	Veterans Cemeter	7	2007		Bear, Dela	ware
permit Depar Impor		21. Signature of Funeral Service Lice	ensee	H	2. Name and Add	ress of Facili e for	<sup>iy</sup> Funera	ls. P.	Α.	
Physician /Medical Examiner physician and physician and the prijel-transit the prijel-transit physician and physic	dicai Examiner	23a. Part1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infitiated events resulting in death) Last	b. Due to (or as a consection of the consection).	equence of):	iter the mode of d	ying, such as	cardiac or re	spiratory arre	st,	Approximate Interval Between Onset and Death
ficate p phys	edic		d							
The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3	⊒Ectopic pregnar ⊒ Other (specify)				23d. Date of deliv Month	ery Day Year
s that ned b	by Pt	Part If. Other significant conditions	contributing to death but not re	sulting in the	underlying cause	given in Part I	1.	23e. Did tob	acco use contribute to	the cause of death?
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aw re	Completed							24a. Was an	24b. Were aut	opsy findings available
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ian: artifica ctor,	Be C	25. Was case referred to medical examiner?				26. Place	e of Death (Ci			
Physician: r this certifica	10	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2	☐ ER/Outpatie	nt 3 DOA	Other: 4 No	ursing Home	5 🗌 Resider	nce 6 Other (Speci	fy)
ng Ph tter th		27. Manner of Death  1 ■ Natural 5 ■ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of finitury	of 28c. in	jury at fork?	28d.	Describe hor	w injury occurred	
To the Hospital or Attending Physicien: The I within 24 Hours after death. To the Funeral Director: Atter this certificate he completely filled in by the funeral director, page	Certification:	2 Accident Investigation 3 Suicide 6 Could not determined	28e Place of Injuny - At	home, farm, si		∐Yes 2∐ e	-	Location (Str. City or Town,	eet and Number or Rur State)	al Route Number,
To the Hospital within 24 hours a Formeral I completely filled	edicai (	29a. Certifier ertifyin P (Check only Medical xa	hysicia To the best of my ki miner: On the basis of examinand manner stated.	nowledge, dea nation and/or in	th cecumed at the rvestigation, in my	time, date at y opinion, dea	nd place, and ath occurred a	dua to the ear it the time, da	uso(s) and mariner as te and place, and due t	othe cause(s)
To th within To th comp	Me	29b. Signature and title of certifier	/			nse number			d. Date signed (Month,	
		<i>▶</i> /#/// <sub>2</sub>	ил.		(1)5	3/07	3		OZJULO	7
R		30. Name and address of the rion who	completed cause of death (Ite	817 C	Print) HRIHM	on) (	CON	Ntw.	OZJULO LASTIE D	E 19770
Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature	1			-		

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 11:SOPM hristine 2007 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner of Mayland Madical Bultimore University 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month Day, Year 7 DEC 21 1937 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months Hours Min. 1 □ M 2 V F PENNSYLVANIA 174-32-4068 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. nnt: if item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r 28a-f show notified at 1y□Yes 2□No Director PRINCE GEORGE'S GLENN DALE MD 10g. Citizen of What Country? 10e Street and Number 10f Zin Code d other than "natural", or items 23a or event, the Medical Examiner must be U.S.A. 20769 10807 GLENSHIRE DRIVE Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married BLACK 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 þ Specify. 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE BILLING SUPERVISOR 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MYRA HANSEN VARDARO JAMES injury or other traumatic ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10807 GLENSHIRE DRIVE GLENN DALE, MARYLAND 20769 RAYMOND H. CHESTNUT/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriai 2 ☐ Cremation 3 ☐Removal from State 4 □ Donation 5 Other (Specify) RIVERDALE CREMATORY 6/22/2007 RIVERDALE, MARYLAND Funeral Service Licenses 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 Approximate Interval Between Onset and Death 23a Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, immediate Cause (Final Sepsis **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Pancreatic Cancer Metastatic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine attending physician and for use as the burial-transit requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death ed by the a 9□Unknown has been signed by ge 2 should be detac 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 **3** No 1 ☐ Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ♣ No 24a. Was an autopsy performed? page certificate 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Yes 2 KNo 2 ☐ ER/Outpatient 3 ☐ DOA P

Division or Vital Records, P.O. Box 68760. the Hospital or Attending Physician: nin 24 hours after death. the Funeral Director: After this certifica funeral director. within 2. 10

27. Manner of Death 1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

(Check only

29b. Signature and title of certifier

5 ☐ Pending investigation

6 ☐ Could not be

Certification:

Medical

State Registrar

Bartes 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 93 Green St. 2120 elissa

28b. Time of

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

1 ☐ Yes 2 ☐ No

М

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

28a. Date of Injury

and manner stated.

(Month, Day Year)

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				State of Mai	ylallu / i	Department of Certificate of		nentai my	Reg. No	5
ı	Physic	ian	1. Decedent's Name (First, Middle, Li	est)				2. Date of D Month	eeth Dey	3. Time of Death
	Physic /Medi		ROGER LEONARD	WATHEN				JULY	3,2007	
-	Exami	ner	4e. Fecility Name (If not institution, gi 11755 EDGE HI				4b. City, Town, or L NEWB		th 4c. County CHARL	
	Funeral Director	Ŋ,		Sex 7. Age (I	n yrs. last bil 69	thday) If Under 1 Year Yrs. Months Days		8. Date of Bi (Month, D 3 – 24 –	irth ey, <i>Year)</i> -1938	9. Birthplace (State or Foreign Country) MD •
	land		10a. State 10b. County	10	Oc. City, Tow	n or Location				10d. Inside City Limits
	Many a-fsh	호	MD. CH	ARLES		NEWBURG	3			1 ☐ Yes 2√☐ No
	h with the 23a or 28 st be not	Funeral Director	10e. Street end Number 11755 EDGE H	ILL ROAD		10f. Zip Code 206	564		10g. Citizen of V	
21215-0020	s 1 and 2 should be filed within 72 hours efter death with the Maryland Health end Mentel Hygiene. Health end Selection in the Selection of thems 23a or 28a-f show then 27 is marked other than "netural", or items 23a or 28a-f show other treumstic avant, the Medical Evantine roust be notified at	ğ	11. Marital Status  1 Never Married 3 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1  Yes 2 No If Yes, Give Year or Dates:	or in U,S.	13. Was Decedent of If Yes, specify Cut 1 ☐ Yes 2 ☒ No		ecify Yes or N Rican, etc.)		e - American Indian, ck, White, etc. :: WHITE
5-0	72 hc	etec	15. Decedent's E (Specify only highest gr	ducation ede completed)	16a.	Decedent's Usuel Occu (Give kind of work done life. DO NOT use retire	petion during most of work	ina		usiness/Industry
121	Man vithin	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)					HARDE	
d 2	filed v Hygie ther t		17. Father's Neme (First, Middle, Las	)	S	PORE OWNER	18. Mother's Nam	e (First Middle	RESTUR	
an	d be antel red o	To Be	FRANCIS LE				MARY R			10)
Maryland	2 should be filed within end Mentel Hygiene. is marked other than eumatic avant, the M	=	19a. Informant's Name/Relationship	Type, Print)	19b	. Meiling Address (Stree				Stete, Zip Code)
	and 2 ealth e n 27 is		DELORES WATH	EN-SPOUSE	1	1755 EDGE	HILL RD	. NEWE	BURG, MD	. 20664
Baltimore,	Pages 1 and 2 ent of Health e nt: if item 27 is ry or other tre		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	Removal from State				Date		City or Town, State
Balti	permit. Pages 1 Depertment of H Important: if ite any injury or ot		21. Signature of Funeral Service Lice	nsee MOO479	C	22. Name and Addre RAYMOND	ess of Facility FUNERAL	SERVI		
	*		23a. Part1. Enter the disease, or com shock, or heart failure. List only	unlications that caused the	death Do	LA PLATA			arrest	Approximate
	Physician /Medical Examiner	iner	Immediate Cause (Final disease or condition resulting in death)	a. 601	5	hut wonsequence of):				Approximate Intervel Between Onset end Death
ů Ž	an end niel-trans	Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	D. Due	s to (or as a v	.ပဂဒဗ်ဍဖစ်ဂပစ် ပါ <u>၂</u> .				
Box 68760, CL	certificate be executed nding physician end use es the buriel-transit	n/Medical	Cause (Disease or injury that initiated events resulting in death) Last	d.	to (or as a c	onsequence of):				
ĕ	deeth cer e ettendir d for use	icia	Part II. Other eignificent conditione of	contributing to death but n	ot resulting in	the underlying cause of	ven in Pert I	23h Did	tobecco use cor	ntribute to the ceuse of deeth?
0.	es that the de igned by the e be deteched i	by Physician/M	Tatin Only diginionic conduction	onthouting to death but the	or resulting in	The underlying cause gr	ven in Feit I.		Yee 2□No	
Division of Vital Records,	aw requii is been s 2 should	Completed b							s en eutopsy ormed?	24b. Were eutopsy findings availeble prior to completion of cause of death?
Œ	The laste has pege	50						10	Yes 2. No	1 □ Yes 2Ø No
ita Ita	iclan: Th certificate irector, pe	Be	25. Was case referred to medical exeminer?				26. Place of Deat	h (Check only	one)	
<del>_</del>	Physician: r this certific ral director,	ျ	11⊠ Yes 2□ No			pation on bort			idence 6 □Oth	
ň	Ing P	ion:	27. Menner of Death 1 □ Naturel 5 □ Pending	28a. Dete of Injury (Month, Day Ye		ime of 28c. Inju		-	how injury occurr	4
Sic	Attending or death.	licat	2 ☐ Accident investigatio 3 ☐ Suicide 6 ☐ Could not b	0 17701	1	m, street, factory, office	Yes 2 No		-	er or Rural Route Number,
<u>∻</u>	or A efter Dire d in b	Certification:	4 ☐ Homicide determined	building, etc. (S	pecify)	•		Other and Tal	wn, State)	hill Rd
	To the Hospital or Attending Is within 24 hours efter death.  To the Funerel Director: After completely filled in by the funer	edical C	29a. Certifier (Check only one)  1 Certifying Ph 2 Medical Exar	yeician: To the best of miner: On the basis of exa	y knowledge imination and	deeth occurred at the ti	me, date end piece, opinion, death occurr	and due to the	cause(s) and me	nner es stated.
	To the within To the compl	Me	29b. Signature and title of certifier  (gulling M.			29c. Licens	se number 05508 8	33		(Month, Day, Year)
	0,		30. Name end address of person who		(Item 23e) (					,
	-01	to-	31. Date filed (Month, Day, Year)	32. Registrer's	Signature					
	Sta Registr	ar		787 Assess	J.	Ball.				

DHMH 16 Rev 6/95

			For State Registrar	State of Mar		artment of He rtificate of D		, 0	ene 3. No.	
*	Physici		Decedent's Name (First, Middle, Last)     CATHER	INE ANN	Į.	VANDLESS		Date of Death     Month	Day Year 28 2007	3. Time of Death 1835 M
	/Medic Examin		4a. Facility Name (If not institution, give s			4b. City, Town, or	Location of Death		4c. County of Death	1000
	71		WMHS-BRADDOO			CUMBERLA			ALLEGANY	
	Funeral Director		219-34-6430	7. Age (	In yrs. last birthday) 69 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Y	rear) Coun	lace (State or Foreign stry)
	land ow		Usual Residence of Decedent  10a. State 10b. County	1	0c. City, Town or Lo	cation			1	0d. Inside City Limits
	Mary a-f sh	tor	MD Washington	n	Hancock					1 XYes 2 □ No
	ith the or 28	Director	10e. Street and Number			10f. Zip Code		10g	g. Citizen of What Coun	itry?
	ath w		303 Quaker Creek			21750			USA	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	Į.	Was Decedent of His f Yes, specify Cubar 1 □ Yes 🌠 No	spanic Origin? (Spec n, Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	etc.
Maryland 21215-0036	2 hour	ted t	15. Decedent's Edu	cation	16a. Deced	lent's Usual Occupa	tion	16	WII. 3b. Kind of Business/Ind	ite Justry
215	thin 7; an "n M-di	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done do OO NOT use retired)	uring most of workin	g		•
7	ed wil	Con	8		Hot	memaker			Own Home	
and	12 should be filed w n and Mental Hygie 1 <b>Is marked other t</b> raumatic event, th	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name		,	
Ĕ	should be and Mental s marked o umatic eve	ဥ	Raymond Brown  19a. Informant's Name/Relationship (Ty)	oe. Print)	19b. Mailin	ng Address (Street a		n Arbutu Route Number (	S City or Town, State, Zip	Code)
	1 and 2 s Health au em 27 Is ther trau		Chris Fox/Daughter	•					Springs,WV	
ore,	es 1 a of He Filtern rothe		20a. Method of Disposition		20b. Place of Dispo- cemetery, cren	sition (Name of natory or other place	Da Da	ate 20	C. Location - City or To	wn, State
Ĕ	Pages ment of I ant: If Ite		1 ☐ Burial 2 【XCremation 3 ☐ R 4 ☐ Donation—5 ☐ Other (Specify)	emoval nom state	Smithsburg		1 .	/07 Si	mithsburg,	MD
Baltimore,	permit. Departm Importa any Inju		21 Signature Funeral Service Los Se	Have		Name and Address	14	41 West	Main Street	
	Physician /Medical Examiner	Y (	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused the cause on each line.  Due to (or as a content of the cause)	e death. Do not ente	er the mode of dying	, such as cardiac or	respiratory arres	t,	Approximate Interval Between Onset and Death
		e.	Sequentially list conditions,	Due to (or as a c	onsequence of):					
8	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							
68760,	ficate be executed g physician and is the burial-transit		resulting in death) Last	Due to (or as a c	onsequence of):					
_		<b>l</b> edical								
.O. Box	the death certifi y the attending I iched for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome pf 1□Live birth 2 [ 4□Pregnant at tin 9□Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ry Day Year
rds, P.	quires that the de n signed by the a lid be detached t	þ	Part II. Other significant conditions con	tributing to death but r	not resulting in the ur	nderlying cause give	n in Part I.		cco use contribute to th	
Vital Records,	: The law requires that the cate has been signed by the page 2 should be detache	Completed						24a. Was an autopsy performe 1∐ Yes 2 ☐	prior to con death?	psy findings available npletion of cause of 2 \square No
/ita	siclan: Th certificate rector, pag	Be	25. Was case referred to medical examiner?				26. Place of Death		2110	
9	Physic this c	2	1 ☐ Yes 2 ☐ No		2 ER/Outpatient		4 LI Nursing Hom		ce 6 ☐Other (Specify	)
	ding I	ion	27. Manner of Death  1	28a. Date of Injury (Month, Day Y	ear) 28b. Time of Injury	Work	at ? es 2 □ No	3d. Describe how	injury occurred	
DIVISION	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifics completely filled in by the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director director, the funeral director, the funeral director director, the funeral director director, the funeral director director director director director, the funeral director direc	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury building, etc. (	- At home, farm, stre Specify)			3f. Location (Stree City or Town, S	et and Number or Rura State)	l Route Number,
	e Hospita 124 hours e Funeral letely filled	edical C	29a. Certifier (Check only one)  1 Certifying Phys 2 Medical Examin	lician: To the best of r ner: On the basis of ex and mariner stated	amination and/or inv	occurred at the time restigation, in my op	e, date and place, a inion, death occurre	nd due to the cau d at the time, date	se(s) and manner as st e and place, and due to	ated. the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier			29c. License	number	29d	I. Date signed (Month, I	Day, Year)
•			1 ( day)	2		1)3	360710	60	June 241	2007
	5		30. Name and address of person who co	mpleted cause of deat	4		Wive Cun	hadanal	1 Manylon	
·	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's	Signature	242 1	, r c Cur	STO GALLO	, cuquit	. & , 55 %
				A STATE OF S						

DHMH 17 Rev 1/2001

ORIGINAL

			Plea	se Type oı											•		
•	7.		For State	State	of Ma	arylan		•					lental Hy	/gien	е		
			1 - State Registrar  1. Decedent's Name (First, Middle	Local			(	Sert	iticate	e or i	Death		2. Date of D	Reg. No	0.		3. Time of Death
	Physici		i, becedent a Name (1 ii at, middin		e Te	lsamo	re	Wi1	son				Month	Da	ay Yea		11:06AM
	/Medic Examin		4a. Facility Name (If not institution							Town, or	Location	of Death	JUIK		c. County of D		J
	00 at 10 at		Washington Co	unty Hos	oita	1					erst						ngton
¥ 3.	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 <b>∑</b> F	7. Ag	e (In yrs. I			If Under Months	1 Year Days	If Under Hours	Min.	8. Date of B (Month, D	ay, Year	7)	Coun	
J.A.	Director		196-14-3131 Usual Residence of Decedent			81		10.					Sept.	10,	1925	<i>A</i> .	rizona
	ryland how		10a. State 10b. County			10c. City	, Town	or Loca	ation							1	Od. Inside City Limits
:	e Ma 8a-fs etified	ctol		ington							vill	e					1 MYes 2 No
	z should be flied within 7.2 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	Funeral Director	10e. Street and Number	Will Desi					10f. Zip		67			10g. C	itizen of What		try?
3	ns 23	eral	13715 Village I	12. Was De		Ever in U.s	S. T	13. W	as Deced	217 lent of H		rigin? (Sp	ecify Yes or N	o- I	U.S.A 14. Race - A		an Indian,
0	or Iten		1 □ Never Married 2 □ Marr	Armed lied 1 ☐ Yes	Forces?								ecify Yes or N Rican, etc.)		Black, W	hite,	etc.
9500-512	ours a ral", o Exan	d by	3 ☐ Widowed 4 💆 Divorced	If Yes, ( Year or	Dates:			11	□Y <i>e</i> s :	SINO	Specify	·:			Specify:	Wł	nite
ָה ה	"natu	etec	15. Deceden (Specify only higher	t's Education at grade completed	1)		16a. [	Decede Give ki	nt's Usua	al Occup	ation during mos f)	st of work	ing	16b. I	Kind of Busine	ss/Ind	dustry
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ָ ס	Hygi Other ent, t	Be Co	17. Father's Name (First, Middle,	Last)								er's Name	e (First, Middle	_		, 01	
yland	Mental Mental rked o tic eve	To B	Wallace Wilse	on								Telsa	more S	nyde	er		
E -	s 1 and 2 should f Health and Men Item 27 is marke other traumatic	'	19a. Informant's Name/Relations	hip (Type. Print)				_							or Town, Stat		
≥ ; ⇔ .	l and Health Im 27 Iher tr		Dirk W. Coble  20a. Method of Disposition	(Son)		20h P							sburg, Date		nsylva Location - City		
Baitimore,	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tra		1 ☐ Burial 2 ☑ Cremation		m Stat <i>e</i>				tion (Nan atory or o		1	Jul	y 2,				
֡֞֜֜֜֜֜֜֜֜֝֟֜֜֓֓֓֓֓֟֜֜֓֓֓֓֟֜֓֓֓֓֓֓֟֜֜֓֓֟֓֓֓֟֓	artme artme ortani injury		4 □ Donation 5 □ Other (S 21. Signature of Funeral Service			SILL	LIISI		g Cre		ss of Facil		7.7.		s Fune		Maryland
n	Dep Imp		Telle for	Davis	< /	M014	14	12:	525 i	Brad	bury	Ave.					and 21783
€ "	DE		23a. Part1. Enter the disease, or shock, or heart failure. List	complications tha	t caused each li	I the death	. Do no	ot <i>e</i> nter	the mod	e of dyin	g, such a	s cardiac	or respiratory	arrest,			Approximate Interval Between
	hysician		Immediate Cause (Final disease or condition	_a. <i>U</i>	m	sex	Ar	OH	car	1	faul	ure	ر ا				Onset and Death
	/Medical Examiner		resulting in death)	Due t	o (or as	consequ	ence of	f):									
		er	Sequentially list conditions, if any, leading to immediate	D		a consequ										+	
\$	d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	<b>S</b> .													
o	se executed cian and ourial-transit	Exa	resulting in death) Last	Due t	o (or as	a consequ	ence of	f):									
68/60,	iaw requires that the death cermicate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	dical		d													
X	ding p	Physician/Medica	IF FEMALE:	23c. If yes, o	outcome	pf pregna	ncv								23d. Date of	dolive	201
POX	atter for u	iciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No	1 ☐ Live 4 ☐ Pre	e birth gnant a	2 ☐ Fetal t time of de	death		Ectopic pr Other (sp		′			ŀ	Month	denve	Day Year
<b>O</b>	by the	hysi	9□Unknown	9□Unl	known												
S,	sician; The law requires that the or certificate has been signed by the rector, page 2 should be detached	by P	Part II. Other significant condition	. 11,	death b	ut not resu	Iting in	the und	derlying c	ause giv	en in Part	1. 10 :			/		ne cause of death?
cords,	een s	ted	Taparans	000,100	The				~,		7401	or ca	/	] Yes			eably 4 □Unknown
ec	e iaw has b je 2 sl	Completed	Deparm	, Aner	me	2							24a. Wa	s an opsy formed?	prior	to co	psy findings available mpletion of cause of
	n: The ficate harr, page		OF Mes sons referred to medica								00 51-	( D	1□ Yes	2 Z	10	es .	2 No
VITAL	rnysician: r this certific ral director,	o Be	25. Was case referred to medica examiner? 1 ☐ Yes 2☐ No	Hospital:	Inpatie	ent 2 🗆	ER/Outr	oatient	3 🗆 DC	OA Oth	or:		h <i>(Check only</i> ome 5□Re		6 □Other (5	Snecit	iv)
0	g rny ter this neral c	n: To	27. Manner of Death	28a. Da		iry	28b. Ti			28c. Injur Wor		Tursing Ti	28d. Describe			респ	<i>y)</i>
101	endin ath. or: Aff he fur	atio	Natural 5 Pendir investi	gation		, , , ,			М		Yes 2	]No					
UNISION	or Arr fter de Direct in by t	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	inad 206, Fla	ce of inj Iding, et	ury - At ho c. <i>(Specif</i> )	me, farr /)	m, stree	et, factory	, office			28f. Location City or To			r Rura	i Route Number,
_	ours a leral [		29a. Certifier ,1 Certifyii	ng Physician: To t	he best	of my kno	wledae.	death	occurred	at the tir	ne, date a	and place.	and due to th	e cause(	(s) and manne	r as s	tated.
	to the nospinal of Attending Prysician; within 24 hours after leath.  To the Funeral Direction: After this certific completely filled in by the funeral director,	Medical		Examiner: On the		f examina											
	vithir To th comp	Me	29b. Signature and title of centifie	10					290		e number		_	29d. D	ate signed (M	onth,	Day, Year)
				D.)						DO	062	32	1	6	1281	07	
	n		30. Name and address of person	1111		MAT	151	UT	Didr	4. W	11	7-1-	40		1		
	Sta	te	31. Date filed (Month, Day, Year)	32	Registr	ar's Signa	ture	200	- V	1	I U	V 1	70				
	Registr		700 0 9	2007	2544	1	-	Cour	ar								

			For State Registrar	State of M	larylar		artment o <i>rtificate d</i>		nd Mental	Hygiene Reg. No.	17	
	Physici /Medic		Decedent's Name (First, Middle, Last	Dorothy	F.	Winkle	er		Mont	of Death h Day ne 21,	2007 <sup>Year</sup>	3. Time of Death
	Examin		4a. Facility Name (If not institution, give		,	-21-7		n, or Location of	Death		County of Death	•
1	Funeral		Prince George's  5. Social Security Number 6. S			pital  last birthday)	If Under 1 Y		4 Hrs. 8. Date	of Birth	rince Geo	
	Director			□ M 2 <b>X</b> F	84	Yrs.	Months Da	ys Hours	Min (Mon:	th. Dav. Year)	.923 Was	place (State or Foreign ntry) nington DC
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ty, Town or Lo	cation				1	10d. Inside City Limits
	Maryli-f sho	tor	Maryland Prince (	eorge's			Hv	attsvill	e			1XYes 2□No
	ith the or 28a	Directo	10e. Street and Number				10f. Zip Cod			10g. Citi	zen of What Cou	ntry?
	s 23a	eral	6712 Stanton Roa	ad 12. Was Deceden	t Ever in I	18 112 1	Mac Daggdont	20784	in? (Enosity Voc	or No.	USA 14. Race - Ameri	ran Indian
36	n 72 hours after death with the Maryland "natural", or items 23a or 28a-f show edical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced	Armed Forces  1 Yes 2 If Yes, Give Year or Dates	? 【No		f Yes, specify 0	of Hispanic Origii Cuban, Mexican, No <i>Specify:</i>	Puerto Rican, et	C.)	Black, White,	etc.
2-0036	2 hour	ted !	15. Decedent's Ed	lucation		16a. Deced	dent's Usual O	cupation	a fi con and dia so		nd of Business/In	
7	~ " (3)	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	- life. l		one during most o tired)	or working		<b>-</b>	
LZ 0	be filed within Ital Hygiene. d other than ' event, the Me	CO	12th 17. Father's Name ( <i>First, Middle, Last,</i>	)			Bookk		s Name (First, M		Private	
Maryland	should be f and Mental I s marked oi umatic eve	To Be	Daniel Murphy					F	'rances 1	Funk		
	es 1 and 2 should to of Health and Ment item 27 is marked r other traumatic		19a. Informant's Name/Relationship ( Edward W. Winkler	Type. Print) : (Husbar	nd)			eet and Number on Road,			r Town, State, Zij ID 20784	o Code)
Baltimore,	Pages 1 and the sent of the se		20a. Method of Disposition 1  Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif				sition (Name o natory or other	p <sub>lace)</sub> netery 6	Date 5/28/200		cation - City or T	,
alti	permit. Pages Department of Important: If is any injury or o		21. Signature Funeral Service Licer			22	2. Name and A	Idress of Facility	Rendon-I	Hale Fu	neral Ho	
n	B m m De		Junear 6	Jener				napolis	•		D 20706	
	Physician		23a. Parti. Enter the discusse, of only ock, or heart failule.					dying, such as ca	ardiac or respirat	tory arrest,		Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or a		y failu quence of):	ше					
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	outed id ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Sepsis								
Ď,	ficate be executed physician and s the burial-transit	I Ex	resulting in death) Last	Due to (or a								
08/60	ficate be executed physician and is the burial-transit	edical	~	d. AHOXIC	EIC	ephalop	auiy					
XON	leath certific attending p	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom 1 ☐ Live birth			Ectopic pregn	ancv		4	23d. Date of deliv	•
Э. П	the death certii y the attending iched for use a	Physician/M	in the past 12 months? 1 ☐ Yes 2 🛣No 9 ☐ Unknown	4□Pregnant 9□Unknown			Other (specify			_	Month	Day Year
7	w requires that the de been signed by the should be detached	by Ph	Part II. Other significant conditions of Parkinson's di	contributing to death	but not res	sulting in the ur	nderlying cause	given in Part I.	23e.	Did tobacco u	se contribute to t	he cause of death?
ecords,	requires that een signed b nould be deta								- 1	1 ☐ Yes 2X	□ No 3 □ Proi	bably 4 ☐Unknown
ပို့ မ	has be	Completed	Diabetes melli	tus						Was an autopsy	I prior to co	ppsy findings available impletion of cause of
<u>ra</u>	sician: The law certificate has b irector, page 2 s	e Co	Hypertension  25. Was case referred to medical					26 Place o	of Death (Check	performed? Yes 2 No	1 ☐ Yes	2□ No
>	Physician: r this certific ral director,	To B	examiner? 1 □ Yes 2 ☑ No	Hospital: 1 Inpat	ient 2 [	] ER/Outpatien	t 3 DOA	Other:			G □Other (Speci	fy)
ion or	une Ine		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of In (Month, D		28b. Time of Injury		njury at Work? I □ Yes 2 □ No		cribe how injur	y occurred	
UIVISION	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of ir building, e	njury - At h etc. (Speci	iome, farm, str ify)	eet, factory, off	ce	28f. Loca City	tion (Street and or Town, State	d Number or Run )	al Route Number,
ı	e Hospita 24 hours e Funera letely fille	Medical C	29a. Certifier 1 ✓ Certifying Ph (Check only one) 2 ☐ Medical Exar	ysician: To the bes niner: On the basis and manner s	of examin	owledge, death ation and/or in	n occurred at the vestigation, in I	e time, date and ny opinion, death	place, and due to occurred at the	o the cause(s) time, date and	and manner as s I place, and due t	stated. o the cause(s)
+	To th within To th compl	Me	29b. Signature and title of certifier	<u></u>				ense number			e signed (Month,	
	10		reser	(1. le	900	e, MI	D	0062	-165	0	6/22/	07 LICENTER
	10		30. Name and address of person who TESHOME	completed cause of	death (Iter ∪ ← .	m 23a) (Type,	3001	HOSPITA	LE GEOR	NE CI	10spital	L CENTER Y,MD 2078S
	Sta	te	31. Date filed (Month, Day, Year)	32. Regis		-6	181	-				,, 63

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 30 Month Year Richard Lloyd Wilson 22 2007 4c. County of Death 4b. City, Town, or Location of Death

Physician /Medical **Examiner Funeral** Director death with the Maryland r 28a-f show notified at Director "natural", or Items 23a or Funeral permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examina-Completed by Be **Physician** /Medical

Examiner

burial-tran and physician as the attending p After this funeral

Division or Vital Records, P.O. Box 68760,

Examiner that the death certificate be executed Physician/Medical Attending Physician: The law requires Completed Be Certification: To Director: filled in by ö within 24 hours a completely

4a. Facility Name (If not institution, give street and number) Lanham Prince George's Doctor's Community Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Months | Days | Hours | Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months Days Hours 1**⊊** M 2□ F 68 219-34-9394 06-29-1938 Washington, DC Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits MD Prince George's 1XXYes 2 No Greenbelt 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5819 Cherrywood Lane, #304 20770 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give 1951 — Year or Dates: 1952 1 ☐ Never Married 2X Married 1 ☐ Yes 2 No Specify: White 3 ☐ Widowed 4 ☐ Divorced 1952 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Parklawn Memorial Elementary/Secondary (0-12) College (1-4or 5+) Ground Keeper Park 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Richard Oscar Wilson Elizabeth Catherine McMichael 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda L. Wilson/Wife 5819 Cherrywood Lane, #304, Greenbelt, MD 20770 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 06-25-2007 Brentwood, Maryland Fort Lincoln Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Europeal Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 Part 1. Enter the dise rise, or corpus allons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final peritonitis resulting in death) Due to (or as a consequence of): preu moria Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Septic sh ock Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Vear 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27, Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

31. Date filed (Month, Day, Year

JUN 2 5 2007

Luck Road, Lanham

			1 - For State Registrar	State of M	Maryland		artment o			nd Me	ental Hy	giene	1111		219	9.			
	Dhysis		Decedent's Name (First, Middle, Last)     2. Date of Death											,	3. Time of D	Death			
	Physic /Medi		Lawrence I	I. Young							June	Day 13		<sup>rear</sup> 007	1745	М			
	Examir	ner	4a. Facility Name (If not institution, give				4b. City, Tox	wn, or L	ocation of	Death		4c.	County of	Death					
			Prince George				Milledand		ever1				Princ	e Ge	eorge's	5			
	Funeral Director		5. Social Security Number 6. Se	x ]M 2□F	Age (In yrs. las	it birthday) Yrs.	If Under 1 Y Months D		If Under 22 Hours	Min.	3. Date of Bi (Month, D	ay, Year)			ace (State or ry)				
			220-28-5542 Usual Residence of Decedent		7.4						June 2	9, 1	932	Was	sh., Do	J			
	yland		10a. State 10b. County		10c. City,	Town or Lo	cation							10	d. Inside City	Limits			
	e Ma	çç	DC				Was	shin	ngton						1 XYes 2	2 🗌 No			
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Importent: if Item 27 is marked other then "natural", or Items 23a or 28a-f show expiriging or other traumatic event, If a Medical Expirity or other traumatic event, If a Medical Expirity or other traumatic event.	Director	10e. Street and Number				10f. Zip Co	de				10g. Citiz	zen of Wh	at Coun	ry?				
	ath w	rail	317 Anacostia					2	20019				Unit	ed S	States				
	er de	Funeral	11. Marital Status	<ol> <li>Was Deceder Armed Force</li> </ol>	nt Ever in U.S. s?	13.	Was Decedent f Yes, specify	t of Hisp Cuban,	anic Origin Mexican,	n? (Spec Puerto Ri	ify Yes or No	o- 1	14. Race -	America White, e					
36	s afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 □XYes 2 □ If Yes, Give		-	1 ☐ Yes 2 ☐		Specify:				Specify:		ack				
Maryland 21215-0036	hour		15. Decedent's Edu	Year or Dates															
5	in 72 in 8	Completed	(Specify only highest grad	e completed)		(Give	lent's Usual O kind of work d DO NOT use re	lone dur	on ring most a	of working	7	16b. Kir	nd of Busi	ness/Ind	ustry				
7	with iene.	E	Elementary/Secondary (0-12)	College (1-4o	r 5+)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	_						D						
ਰੂ	filec I Hyg othe	a)	17. Father's Name (First, Middle, Last)				Carr			s Name (	First, Middle	, Maiden		ivat	:е				
ā	Ald be denta	To B	James	Young							Edi	th Ma	ck						
ary	short and N s me	_	19a. Informant's Name/Relationship (T)	pe, Print)		19b. Mailin	g Address (St	reet and	d Number	or Rural I				ate, Zip	Code)				
	and 2 alth alth 127 i		Irene E. Young/	Wife			317 Ana	cos	tia R	Rd	SE W	ach	DC	2001	Q				
altimore,	of He		20a. Method of Disposition		20b. Plac	e of Dispo	sition (Name of	of Ca	m. i	Dat			cation - Ci						
Ĕ	Pag nent ent: i		1 XBurial 2 Cremation 3 ☐F 4 ☐Donation 5 ☐ Other (Specify)	emoval from Stat	.0   _		Nation			5/19/	2007	1	Crian	gle,	VA				
alt	portribution in the second sec		21. Signature of Funeral Service Licens	9 0		22	. Name and A	ddress	of Facility	Ste	wart	Funer	al H	ome					
m	80 5 5 8		John I. S	Leway X	TL			40	01 Be	ennin	ng Rd.	, NE	Was	h.,	DC 200	19			
	Physician /Medical Examiner	ier	23a. Part1. Enter the disease, or complishook, of heart failure. List only of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, the cause. Enter Underlying	Due to (or a	cardial	Infa			such as ca	ardiac or i	espiratory a	rrest,			Approximate Interval Betwee Onset and De	ath			
98760,	icate be executed physicien and s the burial-transit	dical Examin	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or a	s a consequen	nce of):													
C. Box	at the death certifially the ettending I	ysician/Me	ysician/Me	Physician/Me	ysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		e of pregnancy 2	ath 3	Ectopic pregna Other (s <i>pecif</i> )					2:	3d. Date o		y Day Yea	ar
Records, P	gned be de	þ	Part II. Other significant conditions continuiting to death but not resulting in the underlying cause give				e given i	in Part I.		23e. Did tobacco use contribute to the cause of death?  1  Yes 2 No 3 Probably 4 Unknow									
<u> </u>	> 20 20	Completed								_	04. 145								
e L	0 5 0	Ĕ									24a. Was autor		prio dea	r to com	sy findings ava pletion of cau	allable se of			
_		ပိ	25. Was case referred to medical								1 Yes	2 (2LNo	10	Yes 2	.□ No				
5	Physician: r this certific ral director,	o B	examiner?	ospital:		/Outpatient	aCl no.	Othor			Check only o			-		-			
	ding Physician:  After this certific funeral director.	$\vdash$	27. Manner of Death	28a. Date of In	iury 28	b. Time of				-	5 Residue I			(Specify)					
5	Attending F r death. ector: After by the funera	at lo	1  Natural 5  Pending 2  Accident investigation	(Month, D	ay Year)	Injury		Injury at Work? 1  Yes	s 2 □ No	1		,,							
	al or Attendi efter death. I Director: A d in by the fu	ertification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Ir building, e	njury - At home etc. (Specify)	, farm, stre	et, factory, off	ice		28f	Location (S City or Tox	Street and vn, State)	Number	or Rural	Route Numbe	or,			
	To the Hospital or Attencenthin 24 hours effer deatl To the Funeral Director: completely filled in by the	edicai C	29a. Certifier 1 Certifying Physics (Check only one)	icien: To the bes ier: On the basis and manner s	or examination	dge, death and/or inv	occurred at the	ne time, ny opini	date and p	occurred	d due to the at the time,	cause(s) a date and p	and manne place, and	er as sta I due to t	ted. he cause(s)				
	To the to the comp	Σ	29b. Signature and title of certifier				29c. Lic	ense nu	umber			29d. Date	signed (A	Month, D	ay, Year)				
			Mun a. W	S	D			DC1	13778			J	une 1	15,	2007				
	(3)		30. Name and address of person who co	mpleted cause of	death (Item 23	a) (Type, F	Print)												
(			Thomas A. Tesor:	iero, M.I	D. 210	0 Pen	nsy1va	nia	Ave.	, NW	2003	37							
	Stat		31. Date filed (Month, Bay Year)	32. Regis	rar's Sign dire	K	-												

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 5:05PM -00 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Sandtown NIA e Care Wincheder Timo, If Under 24 Hrs. 8. Dale of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign Days Min. 1 M 2 □ F 0 219-03-093 March 21 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside Çity Limits 1 Nes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country S Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White ptc./ 11. Marital Slatus 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify. 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4pr 5+) 12th NA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Şurname) Villiam 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kuth Anderson Apt-608 1701 N Eutaw 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donation 6 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State -12-07 22. Name and Address of Facility 270 Fre dHIL . march Funeral Home etoind, 2129 of ne disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, high failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cay e (Final disease or condition resulting in eath) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 4☐Pregnant at time of death 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Onknown 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 2 No 1 ☐ Yes 26. Place of Death Check only one Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Vursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 28d. Describe how injury occurred

/Medical Examiner physician and s the burial-transit The law requires that the death certiticate be executed the attending phys hed for use as the P.O. Box Division of Vital Records, or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely tilled in by the tuneral director.

**Physician** 

/Medical

Examiner

**Funeral** 

Director

or items 23a or 28a-f ehov diverminat by notified at

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al Hygiene.

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t of Health

Depertment of important: If any injury or gode.

Physician

the Mudicul Exar

other traumatic event,

Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

Completed by Funeral Director

Be 2

Examiner Physician/Medical IF FEMALE: þ Completed Be Medical Certification; To

25. Was case referred to medical examiner? 1 ☐ Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 4 Homicide 29a. Certifier (Check only one)

28a. Date of Injury (Month, Day Year)

28b. Time of

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

290. Signatu	re and title of cer	fillet
	) - 0	
	100g	01 -1

MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year) JUL 1 0

821 32. Resistrar's Signature

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Physician Jope 00500 CH /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner UNIVERSITY OF MARYLAND MEDICAL CE 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 ☐ M 2 ☑ F Director none Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. int: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10c. City. Town or Location 10b. County ms 23a or 28a-f shor must be notified a MD Prince George's Director 10e. Street and Number 4502 Henderson Road Funeral י"natural", or items edical Examiner ת

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5 XOther (Specify) in state Ronald S. Wade

BALTIMORE NIA If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Days Year June 26, 2007 Maryland 10d. Inside City Limits 1 ☐ Yes 2√2 No Camp Springs unk 10f. Zip Code 10g. Citizen of What Country? USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify: Specify: black 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) none none 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) Jewel Anderson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) University of MD Medical Center 22 S. Greene Street Baltimore, MD

Important: If it any injury or o once.

Examiner

Physician/Medical

Completed by

Be

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Certification:

Medical

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Physician /Medical Examiner

Department of

altimore. Maryland 21215-0036

attending physician and for use as the burial-tran been signed by the should be detached has been N page certificate funeral director. this

Division or Vital Records, P.O. Box 68760,

the Hospital or Attending Physician:

within 24 hours after death To the Funeral Director;

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23b. Was decedent pregnant

1 ☐ Yes 2 ☑ No 9 Unknown

in the past 12 months?

25. Was case referred to medical examiner?

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

JUL 1

1 Tes 2 No

1 Natural

3 Suicide

4 Homicide

Immediate Cause (Final

disease or condition resulting in death)

IF FEMALE:

20a. Method of Disposition

21. Signature of

20a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause or each line. aventr Due to (or as a consequence of)

20b. Place of Disposition (Name of cemetery, crematory or other place)

22. Name and Address of Facility

Baltimore,

Due to (or as a consequence of)

Director

23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death

3 DEctopic pregnancy 5 Other (specify)

23d. Date of delivery Month Day

20c. Location - City or Town, State

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an perforn

2. Date of Death

Jun

Date

State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

Day

26

Year

2007

4c. County of Death

3. Time of Death

5.20 PM

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Approximate Interval Between Onset and Death

Year

26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurred

28a. Date of Injury 27. Manner of Death 28b. Time of (Month, Day Year) 5 Pending investigation 2 Accident 6 Could not be determined

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only

1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

2007

0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print).

A Lexander Agthe (MD 22 South Greenstreet, Ballimore, MD 2 1201

Registrar

32. Megistrar's Signature

			Please	Type or Pri							egible.		
		for State Registrar		State of Ma	aryland		artment of F rtificate of	lealth and N Death	/lental Hy		31/20176	2011 20 0 2	
		Decedent's Name	(First, Middle, La	ast)		001	Tineate of	Death	2. Date of D		1	3. Time of Death	
Physici /Medio		tolly	Assion	exper					Month	Day O 4	Year	6:10 AM	
Examir		4a. Facility Name (If	not institution, gi	ve street and number)	CON.	er	4b. City, Town, o	r Location of Death			County of Death		
Funeral Director		5. Social Security Nu n/a		157M 2 1 F	e (In yrs. la	a <i>st birthday)</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D. Dec 31	rth ay, Year)	9. Birthp		
pu »		Usual Residence of I	Decedent 10b. County		10c City	, Town or Lo	ontion					0d. Inside City Limits	
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r 28a- notifi	Director	10e. Street and Num		COII	BCC	NISCOI (	10f. Zip Code			10g. Citize	en of What Cour	ntry?	
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r dea	Funeral	11. Marital Status		12. Was Decedent Armed Forces?		S. 13. \	Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)	0- 14	4. Race - Americ Black, White,		
rs afte r', or i xamin	by F	1 ☐ Never Marrie 3 ☐ Widowed 4		1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	No		1 ☐ Yes 2 ☑ No	Specify:		i		lack	
be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ted		15. Decedent's E	ducation	I	16a. Deced	lent's Usual Occup	ation		16b. Kind	d of Business/In		
ithin 7 ne. nan "n	Completed	Elementary/Secon	fy only highest gr ndary (0-12)	College (1-4or 5	i+)			during most of work d)	ing		<b>.</b>		
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shoul ind Me i mark umati	2	19a. Informant's Nar				19b. Mailin	g Address (Street			per, City or	y or Town, State, Zip Code)		
and 2 salth a n 27 is		Ayele Char	ntal Ass	iongbon/Da	ughte	r 11 E	Holder Co	ourt, Boor	nsboro,	Mary.	land 217	713	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Dispo		Removal from State	20b. Pla ce	ace of Dispo	sition (Name of natory or other place	ce)	Date	20c. Loca	ation - City or To	own, State	
it. Partmen rtant: njury		4 Donation	5 ☐ Other (Speci	fy)	Met	trox	None and Address	8/3/	07	Lom	e, Togo		
permi Depa Impo any i	!	21. Signature of Fun	neral Service Lice	nse D.	_	11	Name and Addre	ss of Facility Huk	bard Fi	unera.	l Home,	Inc.	
No.		23a. Part1. Piter the	e disease, or con	plications that caused	the death.			ns Avenue			, Maryla	Approximate	
Physician		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Cause (Final disease or condition a. Cause on each line.											
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death atten	cian	23b. Was decedent pregnant in the past 12 months?  1 □ Vac 2 □ No.  4 □ Pregnant at time of death 5 □ Other (specify)									23d. Date of delivery  Month Day Year		
t the c by the	hysi	1   Yes 2   No 9   Unknown 9   Unknown											
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ysicia is cert directa	0 0	examiner?		Hospital:	nt 2 □ E	ER/Outpatient	t 3 DOA Oth	_26. Place of Deat er: 4□ Nursing Ho			□Other (Specif	ivi	
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I or Atlanta	Certification:	4 ☐ Homicide	determined		ry - At hon c. <i>(Sp</i> ec <i>ify)</i>	ne, farm, stre	et, factory, office		28f. Location ( City or To	Street and i wn, State)	Number or Rura	I Route Number,	
spital		29a. Certifier 1	1 🔀 Certifying Pi	hysician: To the best	of my know	vledge, death	occurred at the tir	ne, date and place,	and due to the	cause(s) a	nd manner as s	tated.	
To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director, to	edical	(Check only 2 one)	2 ☐ Medical Exa	miner: On the basis of and manner sta	examinati	ion and/or inv	restigation, in my c	pinion, death occur	red at the time	, date and p	lace, and due to	the cause(s)	
To To To Com	Σ	29b. Signature and ti	itle of certifier	80.			29c. Licens	e number		29d. Date	signed (Month,	Day, Year)	
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Registr	ar	JI	UL 1 0 20	107 Marie	1 15.	Apo	Mi)						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1, Decedent's Name (First, Middle, Last) JULY 3, 2007 **Physician** ELEANOR RUTH ROBINETT GAY AYDLOTTE 7:30 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner CHARLES 2731 MORAN DRIVE WALDORF If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** SPRINGFIELD, Ma MAY 11, 1915 Director 320 07 7467 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director MARYLAND CHARLES WALDORF 10g. Citizen of What Country? 10f Zin Code 10e. Street and Number ō 2731 MORAN DRIVE 20604 UNITED STATES Items 23a Completed by Funeral 14 Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. filed within 72 hours after ( Hygiene. 1 ☐ Never Married 2 ☐ Married ☐Yes 2**XX** Baltimore, Maryland 21215-0036 ò 1 ☐ Yes 200 No Specify: Specify: WHITE 3 ₩ Widowed 4 Divorced "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry The Mudical other than Elementary/Secondary (0-12) College (1-4or 5+) LEGAL SECRETARY 12 PRIVATE INDUSTRY permit. Pages 1 and 2 should be file. Department of Health and Mental Hygin important: if item 27 ie market any injury or other any injury or other. 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be JESSE JOHANNAN ROBINETT STELLA MAE ELLIS 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2731 MORAN DRIVE, WALDORF, MD 20604 MERRY LANTZ (DAUGHTER) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) LEE CREMATORY JULY 5 2007 CLINTON, MARYLAND 22. Name and Address of Facility 21. Signature of Funeral Service Licenses LEE FUNERAL HOME, INC 6633 OLD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final TTPIENO SCI ERNIT **Physician** disease or condition resulting in death) /Medical Examiner BRICLA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit The law requires thet the death certificate be executed attending physicien and for use as the burial-tran Division of Vital Records, P.O. Box 68760, Physician/Medical IE FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 Tho Day 4□Pregnant at time of death 5 Other (specify) 9☐ Unknown sete has been signed by page 2 should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were aulopsy lindings available prior to completion of cause of death? 24a. Was an autopsy performed 2 □ No 1 ☐ Yes 2 ☐ No certificete : After this certifice e funeral director, I Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐ No Certification; To Manner of Death 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after deatl To the Funerel Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28I. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide ō 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only onel fo the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

5

State Registrar

31. Date liled (Month, Day, Year) 1 0 2007

d address of person who completed cause of death (Item 23a) (Type, Print)

GEORGE H. WATHEN, M.D. 11345 PEMBROOKE SQUARE #103, WALDORF, MD 20603 32. Registrar's Signature

DHMH 17 Rev 1/2001

20680

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** July 2007 02 6:45 A. Rosemond Adzo Anagli-Vann /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore 3705 Stoneybrook Road Randallstown If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days 1 □ M 2 F Yrs. September 15, 1958 Director 216-51-1388 48 Ghana Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County ir than "natural", or itams 23a or 28a-f shov the Medical Examinar must be nutitied at **Baltimore** Windsor Mill 1 🗌 Yes 🗶 No Maryland Completed by Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 7915 Jody Knoll Road 21244 Ghana Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene.
wit: If team 27 is marked other than 'natural', or Itams 23 with: If team or 21 is marked other than 'natural', or other treumstic avent, Ina Wedical Exemple I male 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ▼No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. African 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 X No Specify. If Yes. Give 3 ☐ Widowed 4 ☐ Divorced American Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Progressive Horizon College (1-4or 5+) Elementary/Secondary (0-12) Assistant Residential Manager 18. Mother's Name (First, Middle, Maiden Sumame) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be Edith Sallah Joseph Anagli ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1443 Roc Drive, Walled Lake, Michigan 48390 f Health a item 27 i John Anagli (Brother) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Depertment of Important: if any injury or once. Druid Ridge Cemetery 07/06/2007 Pikesville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facilitaring Byers Funeral Directors, Inc. 21. Signature of Fune Service Licensee 8728 Liberty Road, Randallstown, Maryland 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic Breast Cancer years **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of by Physician/Medical Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) physicien s the burial Box 68760, IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No for 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 2 X No 2X No 1 Yes To the Hospital or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Friends Hospital: 1 | Inpatient Other 4 Nursing Home 5 Residence 6 Nother (Specific Residence 1 ☐ Yes 2 🛣 No 2 ER/Outpatient 3 DOA 10 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 1 X Natural 5 Pending 1 🗌 Yes 2 No death. investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral [ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medicai (Check only one) 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier D46118 July 02, 2007 my) dress of person who completed cause of death (Item 23a) (Type, Print) 30. Name and Cooper 1447 York Road, Lutherville, Maryland 21093 Janet 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

07-04723

Phillip Calvin Airey, Jc.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

UNK UNK		1- For State	tate of Maryland	/ Departmer			Mental Hy		ı. No.			
Physicia Medical Exami	an/	Registrar  1. Decedent's Name (First, Midd	Phillip C		2. Date of Death	Dav Year	3. Time of Death 1830 hrs					
		4a. Facility Name (if not institution I-295 @ West Nurser	on, give street and number		4b. City, Town, or Location of Death Linthicum				4c. County of De			
Funeral Director		5. Social Security Number 212 88 9206	6. Sex 7. A	ge (In yrs. last birthda 36	ay) If Ur Mon Yrs.		f Under 24Hrs. Hours Min.	8. Date of Birth	(MM/DD/YYYY) 9. I			
v any.		Usual Residence of Decedent  10a. State  10b. County		10c. City, Town or			-			10d. Inside City Limits		
ryland :a-f show	ctor	Maryland Anno	e Arundel	Glen 1	Burnie Tiof.z	Zip Code		100	g. Citizen of What C	1 Yes 2 X No		
ith the Maryland 23a or 28a-f show notified at once.	I Director		Vater Way Ap	t. 103		21060			U.S.A			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Menial Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 she injury or other traumatic event, the Medical Examiner must be neitlifed at once	by Funeral	11. Marital Status 1 Never Married 2 X N 3 Widowed 4 Di	12. Was Deceder Armed Forces 1 Yes 2 vorced If Yes, Give Year or Dates:	3? 2 X No	If Yes, spe	dent of Hispani cify Cuban, Me	exican, Puerto I	ecify Yes or No- Rican, etc.)	White, etc	heican Indian, Black,		
2 hours a	eted b	15. Decedent's Education (Spe Elementary/Secondary (0-12)	ecify only highest grade co	dur		al Occupation ( vorking life. DO			16b. Kind of Busines	s/Industry		
0036 within 7; iene. eer than Medical	Comple	12th			Tow Tr	ruck Dr			Frank's	Towing		
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	17. Father's Name (First, Middle	Phillip C. A	irey, Sr.		18.N		(First, Middle, Ma tha Gree				
MD 21 d 2 should lith and Me n 27 is ma aumatic ev	<sup>2</sup>	19a. Informant's Name/Relations Martha Airey							er, City or Town, Starter, Burnie,	ate, Zip Code) MD • 21060		
Baltimore, I bermit. Pages I and Department of Heal Important: If item		20a. Method of Disposition  1 Burial 2 X Crematio  4 Donation 5 Other S	n 3 Removal from S	tate 20b. Place of E crematory Bayvie	or other place w Crem	e) natory	06/	Date 28/2007	20c. Location - City Baltimon	or Town, State re, Maryland		
Balt permit Depart Impor injury		21. Signature of Funeral Service	Licensee	sund;		nd Address of F Ritchi	GC	nce Funday Bal	eral Servi timore, Ma	ice, P.A. aryland 21225		
Physician /Medical		28a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cares and each line.  Stab wound of cheet and asphysia.										
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	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	b	sequence of):				HIII				
√ pe psit	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	sequence of):								
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Ox 6876 eath certificate a attending phy for use as the	sician/M	23c. If yes, outcome of pregnancy 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify)								very Day Year		
P.O. E es that the digned by the	by Phys	Part II. Other significant condi	tions contributing to dea	th but not resulting in	the underlyi	ng cause given	n in Part I.			to the cause of death?		
Division of Vital Records, P.C. rate death. The law requires that ra fler death.  **I Director: After this certificate has been signed I led in by the funeral director, page 2 should be detail.	Completed							24a. Was ar autops perform 1 Yes 2	y prior t ned? death			
Vital Rec ysician: The his certificate director, page	8	25. Was case referred to medica examiner?	Hospital:	ent 2 ER/Outp	atient 3	26.Place of DOA	Death (Check o		Residence 6 🗸 Ot	hor: Scono		
n of Vi ding Physi n. After this funeral dir	n: To	1 Yes 2 No  27. Manner of Death  Natural 5 Death	28a. Date of In	iury 28b. Tim	ne of Injury	28c. Injury at	Work?	28d. Describe ho	ow injury occurred bed and asphyx			
ivision or Attend after death. Director:	Certification:	2 Accident Inve	stigation Jun 20, 200	I	rs		2 V No		reet and Number or	Rural Route Number, City		
Divis Hospital or A 24 hours after Funeral Directely filted in b		29a. Certifier 1 Certifying P	rmined (Specify) ur hysician: To the best of r	ny knowledge, death			ind place, and	-295 @ West Note: 4 due to the cause	Nursery Road, Lin	tated.		
To the Hos within 24 h To the Fur	Medical	one) 2 Medical Exact 29b. Signature and title of certifications of the control of the certification of the certifi	and manner stated	amination and/or inve	nd/or investigation, in my opinion, death occurred at 29c. License number				it the time, date and place, and due to the cause(s			
		hig h	-			O.C.M.E			June 21, 2007			
1)		30. Name and address of person Ling Li, MD Assista	who completed cause of ant Medical Examine	,	Street, Bal	timore, MD	21201		·			
Sta Regist	****	31. Date filed (Month, Day, Year)	32 Registr	ar's Signature	and ,							
DHMH 17 Rev 1/20	001	-00510	10000	ORIG	INAL			4				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 07 OH 2007 Sauv /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** AAMC 8. Date of Birth (Month, Day, Apr 14, If Under 1 Year | In Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days Months Hours Min.  $\overset{\scriptscriptstyle Year)}{1933}$ 1 ☐ M 2 💢 F Washington DC Yrs 74 Apr Director 219-28-0357 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 28a-f show 1 ☐ Yes 2√∑ No 7 is marked other than "natural", or items 23a or 28a-f st traumatic event, the Medical Examiner must be notified Director MD Anne Arundel Crownsville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21032 USA 1454 Fairfield Loop Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 14. Race - American Indian . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: White Baltimore, Maryland 21215-0036 Specify. þ 3 ☐ Widowed 4 X Divorced Completed unk 16b, Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 73 th and Mental Hygiene. 7 Is marked other than "n. Elementary/Secondary (0-12) College (1-4or 5+) secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Be Doris Virginia Harned Saunders Fleming Weston 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2.
Department of Health a Important: If Item 27 Is any Injury or other traignes. Michael Delilla/son 112 Rocko Drive Myrtle Beach, SC20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Sorrio Ronald S. Wade State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Parl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): **Physician** /Medical Examiner ~~ CU Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be executed attending physician and I for use as the buriat-transit OPO Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 **X**No 1□ Yes or Attending Physiclan: 25. Was case referred to medical examiner? After this certific funeral director, 26. Place of Death (Check only one) Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3 DOA 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 28c. Injury at Work? Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Natural
2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death

To the Funeral Director: A 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aft To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

State Registrar

29b. Signature and title of contifier

31. Date filed Month, Day, Year)

Cher

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. gistrar's Signature

2001

DHMH 17 Rev 1/2001

**ORIGINAL** 

29c. License number

D0061783

29d. Date signed (Month, Day, Year)

21401

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			1 - For State Registrar	State o	f Maryland		artment of I rtificate of				giene Reg. No.	u l	22017
П	Dhusia		1. Decedent's Name (First, Middle		<del></del>			2. Date of Dea	ath		3. Time of Death		
	Physic /Medi		Lois West Blac				July 3,	2007	Year	10:31 AM			
	Exami	ner	4a. Facility Name (If not institution	, give street and nu	mber)		4b. City, Town,	or Location	of Death		4c. Co.	unty of Death	
			Union Hospita	L 6. Sex	7 Ago //g use /e	and failed at a	E1kto		7.4 Hea		1	Cecil	
	Funeral Director		212-26-7088	1 ☐ M 2 ☑ F	7. Age (In yrs. Ia 82	Yrs.	Months Days		Min.	8. Date of Birth (Month, Day Dec 18,	1924	Cou	place (State or Foreign http:// h Carolina
	and and		Usuel Residence of Decedent  10a. State 10b. County		10c. City,	, Town or Lo	cation						10d, Inside City Limits
	Mary -fsh	tor	MD C	eci1	E	1kton							1 ☐ Yes 2√ No
	h the	Irec	10e. Street and Number				10f. Zip Code			-	10g. Citizen	of What Cour	
	th witi	al D	100 Laurel Dri	ve				219	21		-	USA	•
	filed within 72 hours after death with the Maryland Hygiene. uther then "naturel", or Itams 23e or 28e-f show ont, the Mystreal Examinat must be notified at	by Funeral Director	11. Marital Status	12. Was Dece Armed Fo	edent Ever in U.S		Vas Decedent of I Yes, specify Cub	Hispanic Or	rigin? (Spe	ecify Yes or No-		Race - Americ	
36	s afte	y Fu	1 Never Married 2 Marri	ed 1 ☐ Yes If Yes, Giv	2 (X).No ∕e		Yes 2∏ No			rticari, etc.)		Black, White,	
Ş	hour turel	d be	3 XWidowed 4 □ Divorced	Year or D	ates:							ecify:whit	
21215-0036	in 72	Completed	15. Decedent (Specify only highes	t grade completed)		(Give	lent's Usual Occu kind of work done OO NOT use retire	during mos	st of worki	ng unk	16b. Kind o	f Business/In	dustry uni
717	e filed within al Hygiene. I other then '	mo.	Elementary/Secondary (0-12) $11$	College (1	0 (-4or 5+)			-/					
9	be filed within 72 hours after death with the Maryian that Hygiene. ad other then "naturel", or Itams 23e or 28e-f show event, the Marical Examiner must be notified at	BeC	17. Father's Name (First, Middle, I	ast)				18. Moth	er's Name	(First, Middle,	Maiden Sun	name)	
yla	should be and Mental is markad or umatic eve	To	Guy Homer Wes	t				l		Johnson			
Maryland	CJ (G) (D)		Janet Boylan/d	1 1 21 1 2		19b. Mailin	g Address <i>(Str</i> eet Stevenso	and Numb	er or Rura	/ Route Number	r, City or To	wn, State, Zip 2106	
	1 and 1 Health tem 27		20a. Method of Disposition		20b. Pla		sition (Name of	II Koa					
aitimore,	Pages ment of ant: If it ury or c		1 ☐ Burial 2 ☐ Cremation  4 🛣 Donation 5 ☐ Other (Sp	ecify)		metery, cren	natory or other pla	ca)		ato	200. Locatio	on - City or To	own, State
Dail	permit. Pages 1 an Department of Heal Important: If item 2 eny injury or other once.		21. Signatu - uneral Servic L	icens e	irector		Name and Address				Balti	more S	treet
۲		23a. Part J Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											Approximate Interval Between
	Priysician	er w	Immediate Cause (Final disease or condition	, 5110 34400 011 0	and the same of th	17024	Failur						Onset and Death
	/Medical Examiner		resulting in death)	a Due to (	or as a conseque		1.11(0)0						
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ב	e la has ye 2	dwo								24a. Was at autops perform	y	b. Were autor prior to con death?	osy findings available npletion of cause of
	sicien; Th certificate rector, pag	e Co	25. Was case referred to medical			<del></del>				1 ☐ Yes	NO	1 Yes	2□No
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	ding Phys	L ii	27. Manner of Death	28a. Date o		8b. Time of	28c. Injur	4 Nursing Home 5 Residence 6 Other (Specify)					"
NISION A	Attending it death. ector: After by the fune	atio	1 Accident 5 Pending investigation	ation	i, Day Tear)	Injury		k? Yes 2 🔲!	No				
2	r Atter de irecto	ertification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ed Fee. Place	of Injury - At home	e, farm, stre	et, factory, office		2	8f. Location (Str City or Town	reet and Nur	mber or Rural	Route Number,
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	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	29a. Certifier (Check only one)	Physician: To the la xaminer: On the ba and mann	sis of examination	edge, death n and/or inve	occurred at the tine estigation, in my o	ne, date an pinion, deat	d place, ar th occurre	nd due to the ca d at the time, da	use(s) and i	manner as sta e, and due to	ated. the cause(s)
	To the To the To the Comp		29b. Signature and title of certifier	111			29c. Licens	e number		29	d. Date sign	ned (Month, D	Day, Year)
			▶ H	16on_			054	072			031	UL 07	
			30. Name and address of perso		of death (Item 2:	3а) (Туре, Р	rint)	- / )	,				000
			HOUGH STONE	m	817 CH	W2(HM	ans C7	1/2	VE	W(4376	E D	E	9/20
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